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JSNA Chapters:

[Warrington JSNA Wider Environmental Context and Transport Chapter](#)

[Warrington Joint Strategic Needs Assessment Index](#)

[Warrington JSNA General Demographic Profile Chapter](#)

JSNA Data Baskets:

[2011 Census - First Release of Data](#)

[Warrington Lifestyle Survey 2006](#)

[Sport England Active People Survey \(Warrington\)](#)

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Warrington Joint Strategic Needs Assessment (JSNA) 2011 - Health of Ethnic Populations Chapter



The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities.

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Executive Summary

Introduction

It is well documented that Black and Minority Ethnic (BME) groups in the UK generally experience worse health than the overall population. However, some BME groups fare much worse than others, and patterns vary by disease (POST, 2007). It is also recognised that some BME groups suffer much higher rates of poverty and deprivation. Given these inter-related factors, the health outcomes of BME populations are often worse than the population as a whole.

There is a commitment in Warrington, which is described in the NHS Warrington Single Equality Scheme (2012), to ensure equality is promoted and the diversity of staff and service users is valued. The aim of the Single Equality Scheme is to ensure that people from vulnerable communities are treated fairly, have the same opportunities as everybody else in their communities and that the services delivered to these communities recognise their specific needs and requirements.

This refresh of the Health of Ethnic Populations Needs Assessment is based predominantly on data from the 2001 Census and the 2006 Lifestyle Survey (NHS Warrington, 2006). It is recognised that this data is slightly outdated. However, the 2011 Census is not due to report until 2013 and, although a new local Lifestyle Survey is planned, results will not be available before 2013. ([Census 2011 data made available during 2013 will be available here.](#)) More recent intelligence is available from the findings of some qualitative research which was undertaken with vulnerable groups in Warrington (NHS Warrington, 2011). The [research report](#) provides some valuable information about local BME communities and should be read in conjunction with this chapter.

The 2001 Census suggested that 'Non-White British' groups made up 2.2% of the total Warrington population. More recent data from the Office of National Statistics suggests that this has increased to 6.9%. This includes Eastern European communities, which equate to approximately 2% of the 6.9%. The other significant groups are 'Irish' and 'Indian' minority groups.

The socioeconomic classifications of the BME population, taken from the 2001 Census, are largely at either end of the classification (most deprived to most affluent). However, it must be recognised that the population has grown significantly over the past 10 years and the socioeconomic status may be very different today compared with 2001.

The 2006 Lifestyle Survey highlighted that, on the whole, some 'risky health behaviours' were less prevalent within BME populations than the rest of the Warrington population. For example, lower levels of smoking and binge drinking. However, activity levels and obesity prevalence were slightly worse when compared to the local White population. Childhood obesity levels collected via education (2009/10) suggests that certain BME groups have higher rates of obesity at Reception and Year 6.

Currently, recording of hospital activity by ethnic group is not comprehensive or complete. Therefore, further work is required to improve data quality and completeness for ethnicity. This will ensure that the appropriate data is being collected about the local populations.

Key Issues and Gaps

- It is clear from this work, and from the increase in the BME population locally, that there are specific challenges in terms of better understanding the specific needs of local ethnic populations in order to aid effective commissioning.
- Findings from local qualitative research, undertaken into the health needs of vulnerable populations, highlighted that levels of self-reported poor-health amongst BME participants was high, levels of obesity were high, and access to some health services was low. Care should be taken when interpreting these findings, due to the small numbers of participants involved in the research from BME communities. However, it indicates that further work needs to be undertaken to better understand potential health inequalities.

Recommendations for Commissioning

- Work is needed to ensure the systematic recording of ethnicity on patient records.
- Further work is also needed to ensure application of good practice (Single Equality Scheme and Equality Impact Assessments).

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1) Who's At Risk and Why

It is well documented that Black and Minority Ethnic (BME) groups in the UK generally experience worse health than the overall population. However, some BME groups fare much worse than others, and patterns vary by disease area (POST, 2007). Whilst there is evidence to suggest that there is greater variation in the rates of certain disease by ethnicity than by other socioeconomic factors, the relationship is complex, with cultural, generational, socioeconomic and structural factors all interacting and impacting on the differential health outcomes observed. At a national level, many BME groups experience much higher rates of poverty than the White British population, in terms of income, benefits use and worklessness, with many lacking basic necessities and experiencing high levels of area deprivation (Platt, 2002). The relationships, however, are complex (Nazroo, 2003) and some suggest that much of the variation in indicators, such as self-reported health, between and within BME groups can be explained by differences in socioeconomic status.

When looking at health risks within BME communities, both national and international studies have pointed to a lower uptake of breast and bowel cancer screening appointments amongst BME groups (Szczepura et al., 2008). In the UK, this has been particularly identified for breast screening uptake amongst women of South Asian origin (Thomas et al., 2005). From a detection and early intervention perspective, because these communities are not accessing screening and are therefore presenting much later in the pathways, their outcomes are poorer and their mortality rates are higher.

A review of the available literature relating to health service use and access amongst BME groups highlights a range of factors relating to health inequalities and inequities in accessing services (Ghazala, 2007). Key issues for consideration include: accessible information, perceptions of 'ill-health' influenced by cultural attitudes (Thiede, 2005), social and cultural aspects of help seeking behaviour (Edge, 2010), and perceptions of eligibility or candidacy (Dixon-Woods et al., 2006). These issues are visited more fully in the qualitative research undertaken by the NHS Warrington Patient Experience Report, which explores health service use and access amongst vulnerable and marginalised populations.

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2) The Level of Need in the Population

Whilst there is considerable evidence describing inequalities in health status and health outcome between ethnic groups in the UK, most of this information comes from large scale surveys and nationally collected mortality information. Information at a regional or local level is quite limited, due to the lack of relevant regional and local surveys and poor recording of ethnicity on patient records.

Locally, a piece of qualitative research with vulnerable groups was undertaken in Warrington (NHS Warrington, 2011), which explored the views and experiences of health service use and access amongst individuals from vulnerable or marginalised groups, including Warrington's BME population. This report also examined self-assessment of health needs. As the research was qualitative in nature, the sample size for the BME participants is not large and findings should not be considered representative of the entire BME population in Warrington.

2.1) Population: Warrington has a relatively small Black and Minority Ethnic (BME) population. Actual data on the ethnic breakdown of the population is only routinely available from the national Census, thus the most up-to-date actual figures available are from 2001 ([data and charts for populations by ethnicity are available here](#)). Based on this data, 97.8% of Warrington's population stated their ethnic group as 'White'. ([ONS will be releasing census 2011 data during 2013 and will be available here.](#))

Intercensal Experimental Population Estimates, by ethnic group, for local authority districts in England, are produced by the Office for National Statistics. These are available at borough level only and give an indication of likely change in overall percentages since the 2001 Census.

The latest (2010) estimates suggest that 6.9% of the resident population in Warrington belong to an ethnic minority group, compared to 11.6% in the North West and 17.2% in England. This is an increase from 6% in 2007.

Since Eastern European countries joined to the EU, migration to Western European countries has increased. This has led to the largest minority group being 'Other White', which includes Europeans, estimated at 3,900 (2.0%).

The next largest minority groups include 'Irish' and 'Indian', both estimated at 1,600 (0.8%). The 'Pakistani' population in Warrington is estimated to be 1,300 (0.7%). The General Demographic Profile of the JSNA includes further detail on the ethnic population within Warrington.

2.2) Socioeconomic Classification of Local Ethnic Population: Socioeconomic data, taken from the Census 2001 standard tables, shows that, overall, Warrington has a higher proportion of the population in higher managerial and professional occupations than the national average (9.5% compared with 8.6% in England). Analyses by ethnic group within Warrington shows quite wide variation and suggests that BME groups within Warrington are, in the main, at either end of the classification scale.

At the time of the 2001 Census, a much higher proportion (16.5%) of the BME working age population in Warrington were in higher managerial and professional occupations than the local White working age population¹ (9.4%). Although Warrington's figures are higher than the national averages for White population groups (9.4% compared with 8.4%), there is a much greater difference between local and national figures for BME populations; 16.5% locally compared with 8.7% across England as a whole.

At the other end of the scale, 9.4% of the BME population in Warrington had never worked or were long term unemployed, compared to 2.5% of the White population. Nationally, 12.6% of the BME working age population and 2.9% of the White working age population had never worked or were long term unemployed.

This information is out-of-date now, but until results from the 2011 census are available in early 2013, there is no other readily available source that could be used to update the information.

2.3) Self-Reported Health Status: In order to gain an indication of the population's general health, the 2001 Census asked respondents to indicate how their health had been over the previous 12-month period. In Warrington, 9.1% of the White population said their health was 'not good', which is slightly better than the national figure of 9.4%. 5.2% of the Non-White population in Warrington said their health was 'not good,' which is markedly better than the national average of 7.3%.

The proportion of people with a limiting long term illness² (LLTI) also provides a useful indication of population health. In Warrington, 18% of the White population said they had a limiting long term illness. This is marginally lower than the national figure of 18.7%. 10.4% of Warrington's Non-White population reported to having an LLTI, compared to 9.9% nationally. Findings from the 2011 Census on health and LLTI should be available in 2013.

The vulnerable groups study (NHS Warrington, 2011) asked the same questions on self-reported health and LLTI. The results showed that 3 of the 18 BME participants (17%) reported that their health was 'not good'. This is markedly different to the results from the 2001 Census. However, as stated previously, these results are based on a very small sample within a piece of qualitative research and thus the figures are not comparable. The report concluded that overcoming language barriers is an important aspect of supporting patients with LLTIs and strategies should review the appropriateness of current methods of communicating with individuals from more marginalised groups.

2.4) Health Related Behaviour and Risk Factors: During 2006, a Health, Lifestyle and Community Survey was commissioned to better understand local health need and health-related behaviours within Warrington. 7,381 questionnaires were posted randomly to adults (aged 18+) living within the borough boundary. 3,710 valid returns were received ([Warrington Lifestyle Survey 2006 data, charts and maps available here](#)). After discounting void addresses and list inflation, this gives a response rate of 53%. Respondents were asked to report their ethnic group, to allow analysis by ethnicity to be undertaken.

96% (3,537 people) of the respondents who stated their ethnicity reported they were White British. Due to small numbers, an analysis by ethnicity is only possible at the 'White' and 'BME' population level. Even at this level, results should be interpreted cautiously, as proportions are based on very small numbers. The main findings were:

- Higher levels of obesity amongst BME groups - 22% of 'Non-White' respondents reported to be obese compared to 18% of the White population.
- Lower smoking prevalence - 16% of the BME population report to smoke currently, which is considerably lower than the White population smoking prevalence rate of 20%.
- Lower rates of binge drinking - 21% of BME groups recorded as binge-drinkers, compared to 32% of the White population.
- Slightly lower levels of activity - 46% of the BME population reported to lead a sedentary lifestyle, which is slightly higher than the White population percentage of 42%.
- Lower levels of chronic heart disease (CHD) risk behaviours - 4% of 'Non-White' respondents reported having three CHD risk behaviours, compared to 6% of the White respondents.

The NHS Warrington report on vulnerable groups found that two thirds of the BME group fell into the classification of 'overweight' or 'obese'. However, over 80% of the group reported that they do not smoke. As mentioned previously, it is important to note that the findings in the vulnerable groups report are based on a limited sample of the Warrington BME population.

2.5) Childhood Obesity: An annual National Childhood Measurement Programme (NCMP) was implemented in England in 2006. The heights and weights of primary school children in Reception (aged 4 and 5) and Year 6 (aged 10 and 11) are measured and collated during the academic year. The data is anonymised and uploaded onto the NCMP database. NCMP automatically calculates the BMI for each record. The 85th and 95th centile cut-offs from the British Growth Reference curves (1990) were selected by the Department of Health as public health definitions of overweight and obese children in the population, respectively.

At a national level, results from the 2009/10 data collection highlights that amongst Reception pupils, obesity is more prevalent amongst Black African boys and girls. In Year 6, Bangladeshi boys have the highest prevalence, although the difference is not statistically significant.

Local analysis has been undertaken, grouping results from 2008/09 and 2009/10.

2.5.1) Reception: It should be noted that the ethnicity of 60% of Reception children was not known in 2008/09 (this is because schools are not statutorily obliged to store that information for Reception children). However, in 2009/10, the ethnicity of only 1% was unknown.

Of Reception children whose ethnic group is known, only 8% in 2008/09 and 5% in 2009/10 were not White British. There are so few children in most ethnic groups that the confidence intervals are extremely wide. No ethnic groups have significantly different prevalence of overweight/obese children, or of obese children.

2.5.2) Year 6: For Year 6, the ethnicity of only 2% was not known in 2008/09, and almost 0% in 2009/10. Again, however, with such small numbers of BME children (only 7% in 2008/09 and 3% in 2009/10 are not White British), the confidence intervals around the prevalence estimates are extremely wide, and the differences observed are not statistically significant.

2.6) Disease Prevalence: As stated in the introduction, poor recording of ethnicity on patients' records means that local level analysis of differences in disease prevalence between White and BME groups cannot readily be undertaken. Equally, on a national level, gaps in data collection and recording has meant there have been considerable difficulties in fully investigating health inequalities and issues around access to health services (King's Fund, 2006). National level data can be used cautiously as an indication of what likely differences may be expected, but current data limitations mean that these assumptions cannot be tested.

The Department of Health commission a Health Survey for England annually. The survey undertaken in 2004 had a specific focus on the health of ethnic minorities. Key findings for ethnic groups in the Health Survey for England 2004 (NHS Information Centre, 2006) study were:

- **Cardiovascular Disease (CVD) rates were higher in Irish men.**
- Black African men and Chinese women were significantly less likely than the general population to have any CVD condition.
- In almost all ethnic groups, the overall prevalence of ischaemic heart disease or stroke was higher in men than in women.
- Black Caribbean women had the highest rates of angina symptoms
- Adjusting for age, doctor diagnosed diabetes was almost four times as prevalent in **Bangladeshi men and almost three times as prevalent in Pakistani and Indian men.** Pakistani women were five times more likely, Bangladeshi and Black Caribbean women are **three times more likely to develop diabetes compared to women in the general population.**
- Black Caribbean, Indian, Bangladeshi, Pakistani men and women are at a higher risk of Type 2 diabetes.

Research (POST, 2007) identifies that patterns of ethnic inequalities in health vary from one health condition to the next. Some BME groups tend to have higher rates of cardio-vascular disease than White British people, but lower rates of many cancers. The report also describes ethnic differences in the prevalence of mental health conditions, and describes evidence of differences in risk factors and treatment approaches.

Various statistical models have been produced to calculate the expected prevalence of various diseases, both in the overall population and by ethnic group. The models produced by the Association of Public Health Observatories (APHO)³ enables the expected numbers of patients with certain long-term conditions (LTCs) to be obtained by broad ethnic group. Table 1 shows expected numbers for Warrington patients for 2008. The 'actual' (GP recorded) prevalence of various long term conditions can be obtained from the data management system which is in place to monitor the GP contract, known as the Quality and Outcomes Framework (QOF). Unfortunately, this is not broken down by patients' ethnic group. The overall figures are shown in Table 1.

Table 1: Expected Number of Certain Diseases by Ethnic Group

| Ethnic Group | Hypertension | Coronary Heart Disease (CHD) | Chronic Obstructive Pulmonary Disease (COPD) |
|---------------------------|--------------|------------------------------|--|
| White | 47,395 | 7,985 | 4,498 |
| Mixed | 139 | 11 | n/a |
| Black | 158 | 9 | 16 |
| Asian | 378 | 64 | 34 |
| Other | 205 | 12 | n/a |
| Total Expected Prevalence | 48,275 | 8,081 | 4,547 |
| QOF Reported Prevalence | 26,454 | 7,805 | 3,214 |

Source: Association of Public Health Observatories

As Table 1 illustrates, the actual number of patients diagnosed with a long term condition and reported through QOF, is lower than the statistical models suggest may be expected. It should, however, be remembered that, as with any modelled figures, these are estimates only; calculated using statistical data and based on a number of assumptions and proxies. The modelled estimates are for indicative purposes only, and are intended as one of a range of tools aimed at generating discussion in order to help improve the quality of primary care recording and reporting.

As Table 1 also illustrates, the expected numbers of BME patients with specific LTCs is quite small, in keeping with the small BME population within Warrington. In theory, it should be possible for expected disease prevalence generated from the statistical models for BME groups to be compared with data obtained from local GP Practices. However, this would require a manual data interrogation exercise for all GP Practices within Warrington. The feasibility of this piece of work will be explored as part of the rolling JSNA programme.

Footnotes

¹ 2001 Census definition of 'working age' includes all people aged 16 – 74 years.

² Limiting Long-Term Illness covers any long-term illness, health problem or disability that limits daily activities or work.

³ Association of Public Health Observatories, Hypertension Prevalence Model 2007

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3) Current Services in Relation to Need

3.1) Access to Secondary Care: As stated previously, ethnicity has not always been fully recorded on patient records. Including those where ethnic group is not stated and those where the field is null, approximately 3.5% of inpatient hospital records do not have a recorded ethnicity code, which is similar to the position in 2009. Work is needed to improve the quality and completeness of ethnicity coding on inpatient records.

In the interim, preliminary analysis has been undertaken to assess the proportions of inpatient admissions by ethnic category. Table 2 presents inpatient activity data by ethnic group for 2010¹

Table 2: Inpatient Activity Data, by Admission Method and Broad Ethnic Group, January to December 2010 – Actual numbers

| | Elective (Planned Care) | Non-Elective (Un-planned Care) | Other | Total |
|----------------------|----------------------------|-----------------------------------|-------|--------|
| Any White Background | 26,318 | 23,444 | 7,210 | 56,972 |
| Mixed | 36 | 45 | 79 | 160 |
| Asian | 257 | 302 | 273 | 832 |
| Black | 44 | 60 | 30 | 134 |
| Chinese | 85 | 34 | 25 | 144 |
| Any Other | 88 | 200 | 144 | 432 |
| Not Stated | 1,012 | 489 | 132 | 1,633 |
| Null (field empty) | 344 | 90 | 49 | 483 |
| Total | 28,184 | 24,664 | 7,942 | 60,790 |

As Table 3 illustrates, crude analysis of the data available suggests that overall BME groups appear to be accessing secondary care services in lower proportions than may be expected, based on current BME population estimates. Excluding records where ethnicity is 'not stated' or those where nothing is recorded in the ethnicity field, approximately only 2.9% of secondary care inpatient hospital activity in 2010 related to patients from BME groups, when the latest available estimates from ONS suggest that approximately 4.1% of the Warrington population are from BME communities.

The vulnerable groups report found that BME groups have the lowest level of service uptake. Over half of the BME group had not visited a dentist in the last twelve months. Also, just under a third of the BME cohort had not accessed any health service in the last twelve months. However, these results should be considered with caution as the report used a very small sample of the BME population in Warrington.

Table 3: Inpatient Activity Data, by Admission Method and Broad Ethnic Group, January to December 2010 – Percentage of All Stated

| | Elective (Planned Care) | Non-Elective (Un-planned Care) | Other | Total |
|----------------------|----------------------------|-----------------------------------|-------|-------|
| Any White Background | 98.4% | 98.2% | 94.7% | 97.8% |
| All BME Groups | 1.9% | 2.7% | 7.1% | 2.9% |

Analysis of elective or planned care figures in Table 3 suggests potentially even lower levels of access, with activity for BME patients representing approximately 1.9% of all elective activity in 2010. However, this is a very crude analysis, as the age and sex structure of the population has not been taken into account. If the BME populations are relatively younger, they are likely to need less planned care and thus the apparent lower levels of access may actually be equitable.

As stated, there are data quality and completeness issues which need to be investigated. Improved data quality will enable more comprehensive analysis of equity of access to be undertaken. At present, approximately 3.5% of hospital records do not state the patient's ethnic origin. Once this is addressed and rectified, the pattern of access may look less inequitable.

Footnotes

¹ It should be noted that totals in each category include a proportion that have been ascribed based on reasonable assumptions – e.g. coding of A0 or A* ascribed to category A – 'White British'.

4) Projected Service Use and Outcomes in 3-5 Years and 5-10 Years

It is difficult to accurately project likely future ethnic population numbers. Different patterns of migration and immigration will obviously impact future populations and are difficult to predict.

The 2001 Census and the annual ONS experimental estimates have shown that ethnic minority groups account for 73% of Britain's overall population growth. This is attributed partially to immigration, differences in fertility rates also contribute to the growth observed (Kings Fund, 2006). ([ONS will be releasing census 2011 data during 2013 and will be available here.](#))

Since a number of Eastern European countries joined the EU in 2004, migration to Western European countries has increased, although it is difficult to accurately quantify from routine local statistics. The JSNA General Demographic Chapter contains some information on migration from Worker Registration Schemes and National Insurance numbers.

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5) Evidence of What Works

5.1) Cervical Cancer: A meta-analysis (Han et al., 2011) from the USA looked at interventions that increase use of Papanicolaou tests among ethnic minority women. They found that Pap (smear) test use among ethnic minority women is most likely to increase when access-enhancing strategies are combined. They stated that further research is needed to determine whether more tightly controlled trials of such interventions might reveal an improved rate of cervical cancer screening in Hispanic women as well. Among the intervention types, access-enhancement had the largest effect, followed by community education and individual counselling or letters. Combined intervention effects were significant for studies targeting Asian and African American women, but not Hispanic women.

An international (Cochrane) systematic review of interventions to increase the uptake of cervical smear testing (Everett et al., 2011) found evidence to support the use of invitation letters to increase the uptake of cervical screening. There is limited evidence to support educational interventions, but it is unclear what format is most effective.

5.2) Breast Cancer: A Cochrane review (Bonfil-Cosp et al., 2009) aimed to assess the effectiveness of different strategies for increasing the participation rate of women invited to community (population-based) breast cancer screening activities or mammography programs. The review found the following active strategies to be the most effective: letter of invitation and/or phone call, mailed educational material and training activities with direct reminders for the women. Home visits did not prove to be effective.

Masi et al. (2007) also conducted a systematic review of the literature to identify interventions designed to enhance breast cancer screening, diagnosis, and treatment among minority women. The study found that among patient-targeted screening interventions, those that are culturally tailored or address financial or logistical barriers are generally more effective than reminder-based interventions. This is especially true among women with fewer financial resources and those who have never had a mammography before. Chart-based reminders increase physician adherence to mammography guidelines, but are less effective at increasing clinical breast examination. Several trials demonstrate that case management is an effective strategy for speeding the process of diagnostic testing after screening abnormalities have been found.

Han et al. (2009) looked to evaluate the effectiveness of interventions aimed at increasing mammography screening rates in asymptomatic ethnic minority women in the USA. As with Pap tests, the authors found that the most effective intervention was access-enhancing strategies, followed by individually directed strategies. Tailored, therapy-based interventions were more

effective than non-tailored interventions. The authors concluded that the findings suggested a need for increased use of a therapy-based, tailored approach with enhancement of access to improve mammography screening rates among women from ethnic minorities.

A US study by Legler et al. (2002) aimed to assess the effectiveness of particular types of interventions and this benefit for specific populations of women with historically lower use of mammography (older women, women with low incomes and Non-Caucasian women). There was evidence that interventions directed at subsets of populations that have been historically underserved were significantly effective. Although racial or ethnic differences in mammography use are no longer evident, significant differentials in terms of education, income, health insurance coverage and having a usual source of health care still persist. Therefore, access-enhancing strategies are an important compliment to individual- and system-directed interventions for women with historically lower rates of mammography screening, who may lack the resources to readily learn about or obtain these services.

Wells et al. (2011) reviewed the effects of community health workers (CHW) and found that participation in a CHW intervention was associated with a statistically significant increase in receipt of screening mammography. In randomised control trials, participants recruited from medical settings, programs conducted in urban settings, and programs where CHWs were matched to intervention participants on race or ethnicity showed stronger effects on increasing mammography screening rates. The study concluded that CHW interventions are effective for increasing screening mammography in certain settings and populations.

5.3) Obesity Interventions: NICE has produced clinical guidelines for the management of obesity (CG43), which includes notes on the way interventions may be modified for both adults and children in Black or Minority Ethnic populations (NICE, 2006).

A study by Seo & Sa (2010) evaluated the efficacy of interventions designed to prevent or treat obesity among U.S. ethnic minorities. Interventions with more components were more effective than those with fewer components. Interventions with parental involvement and lifestyle interventions were more effective than those without parental involvement or lifestyle interventions, although results were not statistically significant. The study concluded that the evidence indicates that, among U.S. minority children, obesity interventions with three or more components might be more effective than those using fewer components. Parental involvement, lifestyle change, culturally-based adaptation, and interactive computer programs seem to show promise in the reduction of obese ethnic minority children.

Another study by Seo & Sa (2008) looked at psycho-behavioural interventions for preventing obesity in multi-ethnic adults in the USA and concluded that future programs should include individual sessions, family involvement and problem-solving, as well as lifestyle changes. However, the Centre for Reviews and Dissemination (CRD) have raised concerns over this paper as the methods of pooling data and lack of quality assessment cast doubt on the reliability of the authors' conclusions.

Stevens (2010) aimed to identify obesity prevention programmes for middle school-age children and examine which programmes applied interventions specific for ethnic minorities. However, the review failed to identify programmes with effective interventions specific to ethnic minority children. The findings suggested that there was merit in addressing specific factors that influenced the 10 to 14 year old age group. These included: behavioural strategies that increased self-esteem and motivation whilst targeting poor health practices; exposure to television and other sedentary behaviours; neighbourhood safety; and parental inclusion in intervention programmes. Again, however, this study has also been reviewed by the CRD who found that, given the limitations of the review and the unknown quality of the included studies, the conclusions should be treated with caution.

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6) (Target) Population/Service User Views

A piece of qualitative research was conducted by NHS Warrington (2011), which explores the views and experiences of health service use and access amongst individuals from vulnerable or marginalised groups, including Warrington's BME population. This report, also examines self-assessment of health needs.

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7) Unmet Needs and Service Gaps

Local qualitative research undertaken in 2011 (NHS Warrington, 2011) highlights that there may be low uptake of some health services amongst the BME participants. Further work is needed to establish whether this is indicative of the BME population within Warrington, and if so, to better understand the reasons for this.

Evidence from the 2006 Health and Lifestyle Survey (NHS Warrington, 2006) and the vulnerable groups research (NHS Warrington, 2011) suggests that prevalence of obesity is higher amongst local BME populations. Again, further work is needed to better understand the reasons for this, and appraise the evidence regarding effective population based interventions to address the issue.

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8) Recommendations for Commissioning

- Work is needed to ensure the systematic recording of ethnicity on patient records by providers.
- Further work is also needed to ensure the application of good practice (Single Equality Scheme and Equality Impact Assessments).
- Mechanisms need to be developed for improving uptake of screening and early intervention services amongst the BME population. For example, promotion amongst the BME community of the services available, the eligibility criteria and pathways to access.

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9) Recommendations for Needs Assessment Work

This report has highlighted that there are limitations to assessing or describing the health of ethnic populations at a local level. In addition to the data availability and data quality issues that have been highlighted, the small ethnic population within Warrington means that the analysis of data gathered from population based surveys or patient records has to be interpreted cautiously.

Work is needed to address some of the data gaps:

- Patient ethnicity is recorded for all new patient registrations as part of the system in place to monitor GP contracts (QOF). This will mean that, over time, additional information will be available from GP systems to assess levels of access to primary care amongst BME populations, in addition to enabling the comparison of actual prevalence of long-term conditions with the estimates generated by statistical models.
- In relation to the coding of ethnicity, work to improve the quality of secondary care activity data that is received from local Hospital Trusts needs to be progressed.
- The use of the school census could be explored to ascertain whether it would be possible to use this to identify any localised pockets of different ethnic groups.
- Equality Impact Assessments need to be undertaken systematically to help ensure that the needs of BME populations are taken into account when new policies or services are implemented or changed.

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