Diverse Ethnic Communities Joint Strategic Needs Assessment for Peterborough, 2016

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1. Contributors, Acknowledgements & Abbreviations

1.1 Contributors

This Joint Strategic Needs Assessment has been developed and written by a working group in partnership with a range of local stakeholders across health and social care in Peterborough & Cambridgeshire. Working group members are listed below:

Name	Role
Dr Kathy Hartley	Consultant in Public Health Medicine, Peterborough City Council
Dr Fay Haffenden	Consultant in Public Health Medicine, Cambridgeshire County Council
David Lea	Assistant Director of Public Health Intelligence, Cambridgeshire County Council
Ryan O'Neill	Advanced Public Health Analyst, Peterborough City Council
Elizabeth Wakefield	Public Health Analyst, Cambridgeshire County Council & Peterborough City Council
Wendy Quarry	JSNA Programme Manager, Cambridgeshire County Council
Sue Hall	Senior Public Health Administrator, Cambridgeshire County Council
Shakeela Abid	Live Healthy Practitioner Specialist
Adrian McLean-Tooke	Senior Information Analyst, Cambridgeshire & Peterborough Clinical Commissioning Group

1.2 Acknowledgements

We are grateful for the full range of contributions from our local stakeholders. Organisations which have contributed to the JSNA include Peterborough City Council, Cambridgeshire County Council, Circle Housing Group, Cambridgeshire & Peterborough Clinical Commissioning Group, Fenland District Council, Public Health England, Cambridge Council for Voluntary Services, Rosmini Centre, Cambridgeshire Human rights and Equality Support Services, Gladstone Connect, Peterborough iCash, Healthwatch Cambridgeshire & Peterborough, and Cambridgeshire Constabulary.

1.3 Glossary of Abbreviations

A8 - The 8 member states that acceded to become part of the European Union on 01/05/2004 – Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia

A&E – Accident and Emergency

AIDS – acquired immune deficiency syndrome

ASB – anti-social behaviour

C&P – Cambridgeshire and Peterborough

CCG – Clinical Commissioning Group

CD4 count – A measure of the number of helper T cells per cubic millimeter of blood, used to analyze the prognosis of patients with HIV.

CHESS – Cambridgeshire Human rights and Equality Support Services

DAC – Dental Access Centre

DALYs – disability adjusted life years

DSR – Directly age-standardised rates

EU – European Union

FDC – Fenland District Council

GCSE – General Certificate of Secondary Education

GP – General Practitioner

GLA – Gangmaster Licensing Authority

HIV – human immune-deficiency virus

HMO – houses of multiple occupation

IAG - Information Advice & Guidance

iCaSH - integrated Contraception & Sexual Health

ICT – Information and communications technology

JSNA – Joint Strategic Needs Assessment

PHEC – Public Health England Centre

PHOF – Public Health Outcomes Framework

LCG – Local Commissioning Group

L4+ - Level 4 and above

LA – Local Authority

NICE – National Institute of Clinical Excellence

NINo – National Insurance Number

NHS – National Health Service

ONS – Office for National Statistics

TA – teacher assessment

TB – Tuberculosis

UASC – Unaccompanied Asylum-Seeking Child

VPRS – Vulnerable Persons Resettlement Scheme

WHO – World Health Organisation

2. Introduction

It is important that Local Authorities understand the composition and needs of their local population, in order to be able to plan and deliver services effectively, as well as being able to respond to any issues relating to community cohesion or address health inequalities. This JSNA provides a framework for identifying and understanding the needs of diverse ethnic communities in Peterborough to help fulfil these obligations. Peterborough is a City with a growing economy which celebrates the diversity of its residents, and this JSNA will support public services to ensure effective delivery in this context.

The demography, education and health sections of this JSNA use local and national quantitative (numerical) data, together with national research, to provide information on the likely health and wellbeing needs of a range of ethnic communities in Peterborough. The data available comes in two main categories. The first category is data related to people's self-reported ethnic group – for example from the national 2011 Census. The second category is data related to people's country of birth - for example National Insurance or GP registrations.

It's also important to understand the views and experiences of diverse communities, and of wider stakeholders which provide services, through methods such as local survey work, focus groups or stakeholder workshops. This has been piloted with communities of Eastern European origin and the results are included in Appendix A of this JSNA. Similar work will be carried out with other ethnic communities, to provide further Appendices for this JSNA going forward.

Demographic information about the different ethnic groups in Peterborough and about patterns of migration of people born outside the UK, are provided in Chapter 3 of this JSNA. Chapter 4 includes data about the ethnic diversity of children in Peterborough and their educational attainment. Chapter 5 reviews the health and healthcare needs of diverse ethnic communities. Data for Peterborough is often compared to other areas across Cambridgeshire or within the Eastern region or to England. Comparisons in this manner aim to highlight differences and therefore help to identify need that will help commissioners allocate resources.

3. Demography

Key Findings:

- At the time of the 2011 Census, 71% of the Peterborough population was classified as of 'white British' ethnicity. Of the remainder, 'Asian or Asian British' and 'white other' populations formed the largest communities at 12% and 11% respectively. Within the Asian communities, Asian Pakistani or British Pakistani made up the largest community at 7% of the total Peterborough population.
- The total black and minority ethnic (BME) population varied between Peterborough electoral wards from 2.3% to 58.2% of the ward population
- The overall population of Peterborough increased by 17.7% between 2001 and 2011. Within this population, the greatest increases in ethnic categories were seen in the 'white other' group and the Black British or Black African category. There was a slight decrease in the number of people recording their ethnicity as 'white British'.
- Non-UK born residents in the East of England were primarily adults of working age, with 43% aged 20-39 and 71% aged 20-59. In Peterborough 64% of non-UK born residents had one or more dependent children.
- In 2011, 4.86% of the population of Peterborough could not speak English or could not speak English well.
- Between Censuses, other sources of information are used by the Office of National Statistics to estimate changes in non-UK born populations. Within Cambridgeshire and Peterborough, ONS estimates for 2014 indicated that non-UK born populations were highest in Cambridge City and in Peterborough, at 307.1/1,000 residents and 206.3/1,000 residents respectively.
- Over the five years from 2009 to 2014, estimates of net international migration into Peterborough were highest in 2009/10, and lowest in 2011/12. In 2013/14, Cambridge City and Peterborough showed the highest local rates of net international migration at 16.3 and 9.7 (per 1,000) respectivly compared to 4.5 for England and 3.6 for the East of England.
- Information from school and GP registrations can also help to build the picture of demographic changes in Peterborough between Censuses, and these are described in the sections on Education and Health.

The diverse ethnic population of Peterborough

- The census data records information about people by how they describe their ethnicity, based on a choice of various ethnic groupings. This information does not necessarily reflect whether a person is born in the UK or not and therefore whether they are a migrant or not, it simply describes or assigns an ethnic origin to the person. Details of ethnicity within a population are useful to determine the proportion and number of ethnic minority groups. Comparisons between populations on the ethnic mix provides useful information to commissioners on where best to direct resources in order to address any need identified for particular ethnic communities. For the purpose of this JSNA, the census data is useful to identify black, Asian and minority ethnic (BME)and diverse communities within Peterborough and to assess how these populations are changing over recent time periods.

However, caution must be taken to account for the fact that Census data is only recorded every ten years and therefore may not represent a rapidly changing population several years after the last Census was recorded.

The figure below gives a breakdown of the population of Peterborough in terms of overall numbers of people and percentage of the total population, by ethnic origin, as described in the 2011 census.

Figure 1 – 2011 Census data for Peterborough Local Authority area showing population by ethnic categories

Peterbrough - all wards	All categories: Ethnic group	White	White: English/ Welsh/Scottish/Northern Irish/British	White: Irish	White: Any other ethnic group	Mixed/ multiple ethnic group	Asian or Asian British	Asian/Asian British: Indian or British Indian	Asian/Asian British: Pakistani or British Pakistani	Asian/Asian British: Chinese	Black/African/Caribbean/Black British	Black/African/Caribbean/ Black British: African	Black/African/Caribbean/Black British: Caribbean	Other ethnic group: any other ethnic group
Total Number	183631	151544	130232	1257	20055	4948	21492	4636	12078	872	4164	2480	1174	1483
Total %	100%	83%	71%	1%	11%	3%	12%	3%	7%	0%	2%	1%	1%	1%

It is clear that outside the white British population, 'Asian or Asian British' and 'white other' populations form the largest communities (12% and 11% respectively). Within the Asian community, Asian Pakistani or British Pakistani make up the largest community at 7% of the total population.

Population trends of ethnic communities in Peterborough

It is important to determine how populations change over time in order to understand where resources are required and may be needed in the future. By comparing Census data between 2001 and 2011, it is possible to show the ethnic categories within the population that are increasing most rapidly as well as those that may be decreasing (figure 2 below).

Figure 2 – Change in ethnic populations between the 2001 and 2011 Censuses

	All People	White - British	White - Other	Mixed multiple ethnic group	Asian or Asian British – Indian	Asian or Asian British - Pakistani	Black or Black British - Black Caribbean	Black or Black British - Black African	Chinese or other ethnic group - Chinese
2001	156,057	133,751	4,553	2,293	2,878	6,980	1,116	551	531
2011	183,631	130,232	20,055	4,948	4,636	12,078	1,174	2,480	872
% increase 2001-2011	17.7%	-2.6%	340%	115%	61%	73%	5.2%	350%	64.2%

The overall population of Peterborough increased by 17.7% between 2001 and 2011. Within this population, the greatest increases in ethnic categories were seen in the 'white other'

group and the Black British or Black African category (340% and 350% increases, respectively). There was a slight (2.6%) decrease in the 'white British' population.

BME population by Electoral ward in Peterborough (2011 Census data)

Black and minority ethnic (BME) populations usually describe all non-white categories of people in a given population.

The figure below shows how the total BME population varies between Peterborough wards from 58.2% of the population of Central ward to 2.3% of the population of Northborough ward.

Figure 3 – Proportion of the total population assigned to BME groups by electoral ward in Peterborough (2011) and deprivation score for each ward (2015)

Electoral Ward	BME Population (%, 2011)	IMD 2015 (Score, Higher Value = Greater deprivation)
Central	58.2	45.8
Park	35.8	26.0
Ravensthorpe	30.8	42.2
West	29.5	15.3
East	26.8	37.6
North	23.0	42.4
Dogsthorpe	18.4	40.7
Peterborough UA	17.5	27.7
Bretton South	14.8	27.7
Orton with Hampton	14.0	14.5
Bretton North	12.4	39.0
Fletton and Woodston	11.5	23.5
Orton Longueville	10.1	40.5
Paston	9.6	36.9
Stanground East	8.3	25.4
Walton	8.2	25.9
Werrington North	7.4	17.4
Orton Waterville	7.2	17.9
Stanground Central	6.9	24.0
Eye and Thorney	5.0	20.8
Werrington South	4.9	10.6
Newborough	4.7	17.2
Glinton and Wittering	2.8	10.1
Barnack	2.7	9.8
Northborough	2.3	10.1

Light blue indicates higher proportion of BME population than Peterborough average and dark blue indicates below Peterborough average. In general, wards with higher amounts of deprivation as measured by the IMD score have higher proportions of BME populations, although the correlation isn't strict and there are exceptions, for example West electoral ward, with 29.5% BME population and fifth lowest deprivation score.

Population defined by ethnicity in all electoral ward in Peterborough, 2011

The figure below shows the proportion of the population of each (pre-2016) electoral ward in peterborough in each ethnicity group. The data is ranked according to the proportion of the population described with Asian ethnicity. The first eight wards listed lie adjacent to each other, geographically and are in the city area of Peterborough. In contrast, the wards with the highest proportion of 'white British' residents are in wards located outside of Peterborough city – in more rural localities (see Appendix B for map of wards).

Figure 4 – proportion of the population of each electoral ward as defined by ethnicity groups in the 2011 census

Electoral Ward	All categories: Ethnic group	White	White: English/Welsh/Scottish/Northern Irish/British	White: Irish	White: Any other ethnic group	Mixed/multiple ethnic group	Asian or Asian British	Asian/Asian British: Indian or British Indian	Asian/Asian British: Pakistani or British Pakistani	Asian/Asian British: Chinese	Black/African/Caribbean/Black British	Black/African/Caribbean/Black British: African	Black/African/Caribbean/Black British: Caribbean	Other ethnic group: any other ethnic group
Central	100%	42%	17%	0%	24%	4%	49%	3%	39%	1%	3%	2%	0%	2%
Park	100%	64%	41%	1%	22%	3%	30%	3%	23%	1%	2%	1%	1%	1%
Ravensthorpe	100%	69%	55%	1%	14%	3%	22%	5%	10%	0%	4%	2%	1%	1%
West	100%	71%	62%	1%	7%	2%	25%	7%	14%	1%	2%	1%	0%	1%
East	100%	73%	52%	1%	20%	3%	19%	5%	9%	1%	3%	2%	1%	1%
North	100%	77%	57%	1%	19%	3%	16%	2%	11%	0%	2%	1%	1%	1%
Dogsthorpe	100%	82%	68%	1%	13%	4%	10%	3%	5%	0%	2%	1%	1%	2%
Bretton South	100%	85%	77%	1%	8%	3%	7%	4%	1%	0%	4%	3%	1%	1%
Orton with Hampton	100%	86%	77%	1%	9%	4%	6%	3%	2%	1%	3%	2%	1%	1%
Bretton North	100%	88%	76%	1%	10%	3%	6%	3%	2%	0%	3%	2%	1%	0%
Fletton and Woodston	100%	89%	74%	1%	14%	2%	5%	2%	1%	1%	3%	2%	1%	1%
Orton Longueville	100%	90%	80%	1%	9%	3%	3%	1%	1%	0%	3%	3%	1%	0%
Paston	100%	90%	81%	1%	8%	3%	4%	1%	0%	1%	3%	1%	1%	1%
Stanground East	100%	92%	85%	1%	6%	2%	4%	1%	1%	0%	2%	1%	0%	0%
Walton	100%	92%	85%	1%	6%	2%	4%	2%	1%	0%	2%	1%	1%	0%
Werrington North	100%	93%	88%	1%	5%	2%	3%	2%	1%	1%	2%	1%	1%	0%
Orton Waterville	100%	93%	86%	1%	5%	2%	3%	2%	0%	1%	2%	1%	1%	0%
Stanground Central	100%	93%	82%	1%	10%	2%	3%	2%	1%	0%	2%	1%	0%	0%
Eye and Thorney	100%	95%	92%	0%	2%	2%	2%	1%	0%	0%	1%	0%	0%	0%
Werrington South	100%	95%	92%	1%	3%	1%	2%	1%	1%	0%	1%	0%	0%	0%
Newborough	100%	95%	92%	0%	3%	2%	2%	1%	0%	0%	1%	1%	0%	1%
Glinton and Wittering	100%	97%	94%	1%	2%	1%	1%	0%	0%	0%	1%	0%	0%	0%
Barnack	100%	97%	95%	0%	2%	1%	1%	1%	0%	0%	0%	0%	0%	0%
Northborough	100%	98%	96%	0%	1%	1%	1%	1%	0%	0%	0%	0%	0%	0%
Total Number	100%	83%	71%	1%	11%	3%	12%	3%	7%	0%	2%	1%	1%	1%
Total %	100%	83%	71%	1%	11%	3%	12%	3%	7%	0%	2%	1%	1%	1%

Central ward has the highest proportion of Asian Pakistani/British Pakistani residents (39%), followed by Park and West wards, whereas West ward has the highest proportion of Asian Indian/British Indian residents (7%). The location of residents with Black African/Black British African or Black Caribbean/Black British Caribbean ethnicities shows a slightly different patterns to those residents with Asian ethnicies with more spread through the Peterborough City wards below. However, wards located in more rural locations still see an under-representation of these ethnic groups in the population.

<u>The 'White Any Other' population</u>

The 'white any other' ethnic group has been further broken down in this JSNA, into Eastern European and non-Eastern European, as Eastern European migration has been a particular feature of recent years. As shown in the table below, overall, 5.95% of the population of Peterborough in 2011 had an Eastern European ethnicity, with a range for all Peterborough wards of between 0% and 15.1%. . Central, Park, and East wards have the highest population of Eastern Europeans – 15.1%, 13.5% and 12.4% respectively. 4.97% of the Peterborough

population described themselves as of 'white other' ethnicity but were not from Eastern Europe.

Source: Census, 2011, https://www.nomisweb.co.uk/census/2011/qs601ew

Figure 5: 2011 Census data for Peterborough wards ranked according to the proportion of White Eastern European population

Ethnic Group	White Eastern European	White any other ethnicity (not Eastern European)	Rank
Central	15.1%	8.9%	1
Park	13.5%	8.6%	2
East	12.4%	7.9%	3
North	10.9%	7.8%	4
Ravensthorpe	7.9%	5.8%	5
Dogsthorpe	7.4%	5.5%	6
Fletton and Woodston	6.5%	7.1%	7
Bretton North	5.2%	5.1%	8
Orton Longueville	5.1%	4.3%	9
Paston	4.4%	3.8%	10
Stanground Central	4.3%	5.8%	11
Orton with Hampton	4.3%	4.5%	12
Bretton South	3.7%	4.1%	13
West	3.7%	3.8%	14
Stanground East	3.3%	3.1%	15
Walton	3.2%	3.2%	16
Orton Waterville	2.4%	2.9%	17
Werrington North	2.2%	2.3%	18
Newborough	0.9%	1.9%	19
Werrington South	0.8%	1.8%	20
Eye and Thorney	0.7%	1.7%	21
Glinton and Wittering	0.4%	1.9%	22
Barnack	0.3%	1.7%	23
Northborough	0.0%	1.4%	24
Total %	5.95%	4.97%	

Source: Census, 2011, https://www.nomisweb.co.uk/census/2011/qs601ew

Note: Categorisations of ethnicity are as follows:

Eastern European: Albanian, Baltic States (Estonia, Latvia & Lithuania), Bosnian, Russian, Croatian, Kosovan, Other Eastern European, Polish, Serbian

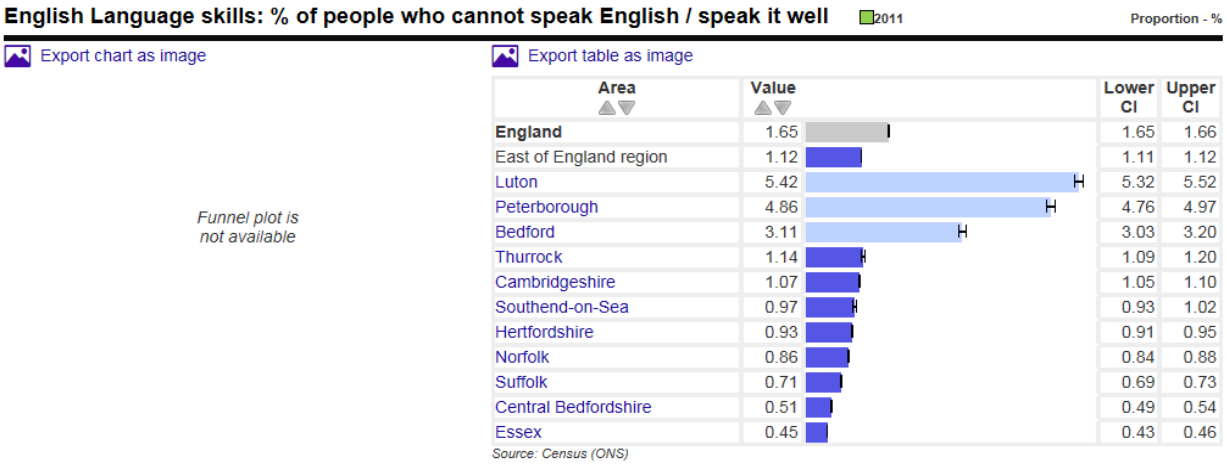
White any other: Afghan, Anglo Indian, Argentinian, Australian/New Zealander, Brazilian, British Asian, Burmese, Chilean, Colombian, Cuban, Cypriot, Ecuadorian, European Mixed, Filipino, Greek, Greek Cypriot, Iranian, Israeli, Italian, Japanese, Kashmiri, Kurdish, Latin/South/Central American, Malaysian, Mexican, Moroccan, Multi-ethnic islands, Nepalese, Nigerian, North

African, North American, Other Middle East, Other Western European, Peruvian, Polynesia/Micronesia/Melanesia, Somali, Somalilander, Tamil, Thai, Turkish, Turkish Cypriot, Venezuelan, Vietnamese, White African, White Caribbean, White any other ethnic group

English language skills

Peterborough has the second highest proportion of the population who cannot speak English or cannot speak English well of local authorities in the East of England (4.86% of the population). This data includes people of all nationalities and therefore does not specifically express the need for English language acquisition in any particular ethnic or diverse community.

Figure 6: % of people who cannot speak English/speak it well, 2011 Census



Source: 2011 Census

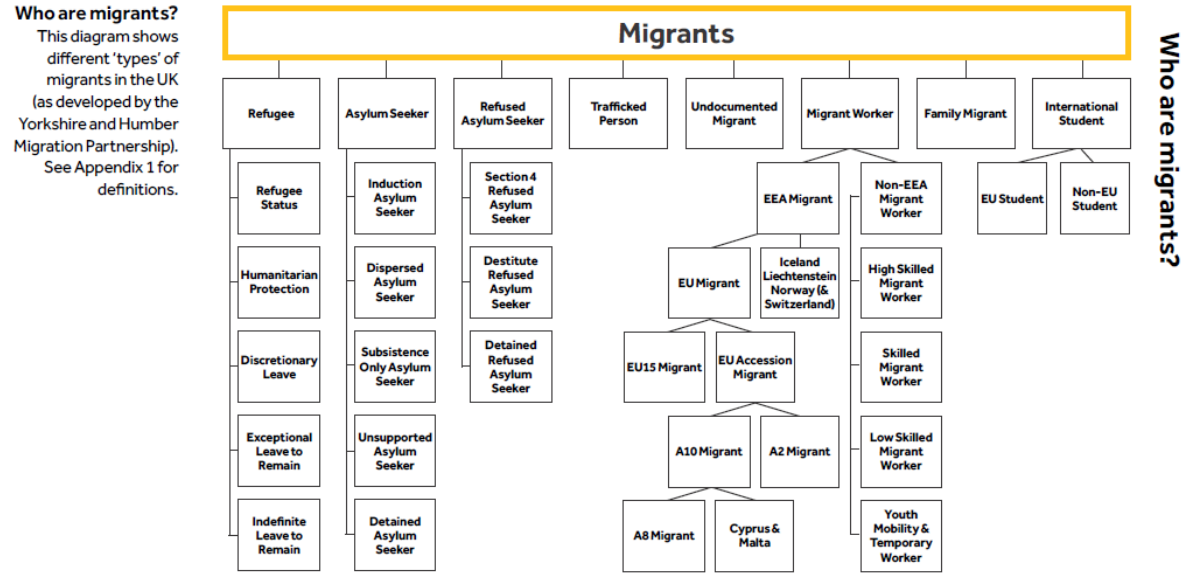
Non-UK born residents and migration

A long-term international migrant is defined as 'a person who moves to a country other than that of his or her usual residence for a period of at least 12 months, so that the country of destination effectively becomes his or her new country of usual residence. From the perspective of the country of departure, the person will be a long-term emigrant and from that of the country of arrival, the person will be a long-term immigrant[1].'

For the purposes of this JSNA, the term 'migrant' is used to describe a person who has moved to the UK who at the time of entry to the UK is not a British national. Migrants are not a homogeneous group, coming from all over the world and with different socio-economic backgrounds. Migrants can be grouped according to the primary reason why they have moved to the UK as shown in the diagram on the next page.

[1] http://www.ons.gov.uk/ons/guide-method/method-quality/specific/population-and-migration/population-projections/faq---population-projections/migration/index.html?format=print#1

Figure 7: Different categories of migrants based on the reason why they have moved to the UK



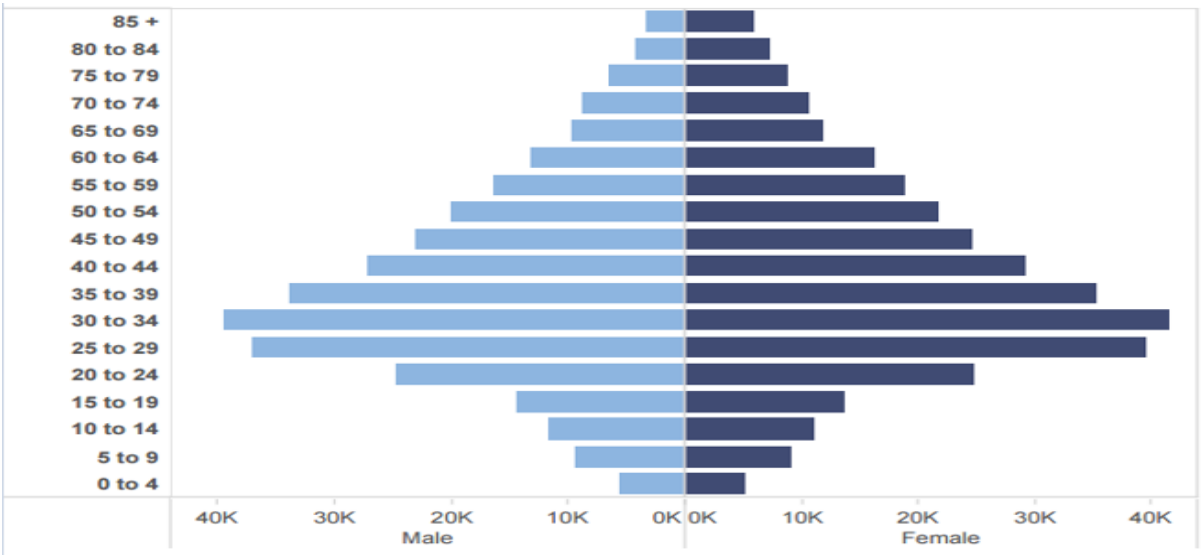
Source: Rose, N., Stirling, S., Ricketts, A., & Chappel, D. (2011). Including Migrant Populations in Joint Strategic Needs Assessment. A Guide.

In terms of data, Migrants can be defined in different ways: by place of birth (i.e. foreign-born), nationality (i.e. foreign citizens), and length of stay in the UK.

Characteristics of non-UK born residents in the East of England – age and sex

The figure below shows the age and sex distribution of people who are resident in the East of England but were not born in the UK.

Figure 8: East of England Migration Patterns, Non-UK born by age and sex, Population Pyramid 2011



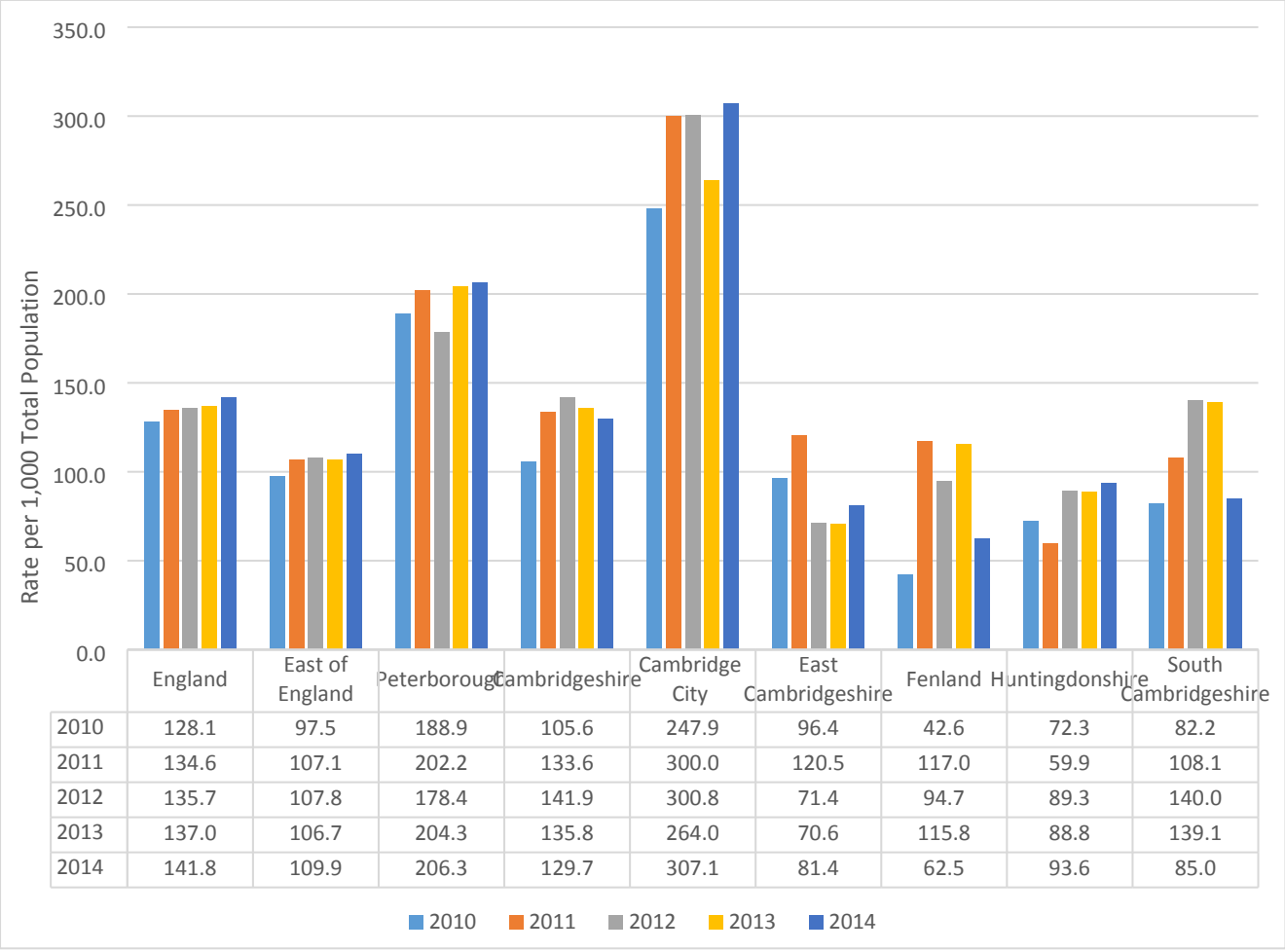
Source: Oxford Migration Observatory, 2015, http://www.migrationobservatory.ox.ac.uk/data-and-resources/maps/census-map-non-uk-born-population-increase-2001-v-2011-england-and-wales

48% of non-UK born residents in the East of England are males and 52% female. Non-UK born numbers are highest among adults of working age, with 43% aged 20-39 and 71% aged 20-59 years of age. The most common age groups for the non-UK born population of the East of England were 25-29 and 30-34, accounting for 12% and 13% of the non-UK born population respectively. In contrast, the general population of the Eastern region shows a more even spread of age categories up to the age of fifty, with the most common age group for people aged 45-50 (data not shown).

The non-UK born population across Peterborough and Cambridgeshire

The proportion of the population which is non-UK born is estimated for Peterborough and each Cambridgeshire district and compared with England and the East of England in the figure below for years 2010 -2014

Figure 9: Estimated rate of non-UK born population, crude rate per 1,000 total population, 2010-2014



	England	East of England	Peterborough	Cambridgeshire	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
2010	128.1	97.5	188.9	105.6	247.9	96.4	42.6	72.3	82.2
2011	134.6	107.1	202.2	133.6	300.0	120.5	117.0	59.9	108.1
2012	135.7	107.8	178.4	141.9	300.8	71.4	94.7	89.3	140.0
2013	137.0	106.7	204.3	135.8	264.0	70.6	115.8	88.8	139.1
2014	141.8	109.9	206.3	129.7	307.1	81.4	62.5	93.6	85.0

Source: Office for National Statistics, 2014, http://www.ons.gov.uk/ons/rel/migration1/migration-indicators-suite/2014/index.html

The proportion of non-UK born people in the population is higher in Peterborough and Cambridge City than those observed nationally.

Trends in non-UK born migration across Cambridgeshire

Data comparing the UK census results between 2001 and 2011 provides information on the rate of change of non-UK born residents over this period. This information is presented in the figure below for Peterborough and Cambridgeshire districts.

Figure 10: East of England Migration Patterns – Non-UK Born Population, 2001-2011

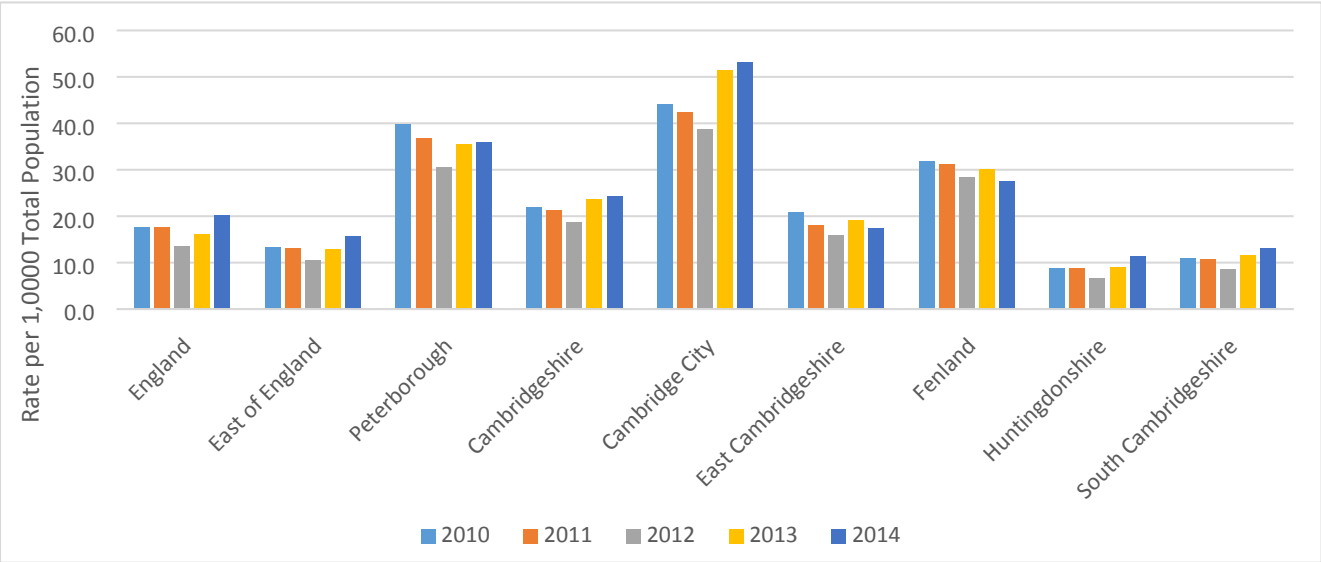
Area	2001 Non-UK Born Population	2011 Non-UK Born Population	Numerical Increase
Fenland	2,641	8,209	5,568
Peterborough	15,268	37,892	22,624
South Cambridgeshire	9,333	16,564	7,231
Cambridge City	20,851	36,381	15,530
East Cambridgeshire	4,973	8,242	3,269
Huntingdonshire	10,822	16,302	5,480

Source: Oxford Migration Observatory, 2015, http://www.migrationobservatory.ox.ac.uk/data-and-resources/maps/census-map-non-uk-born-population-increase-2001-v-2011-england-and-wales

New migration to Peterborough and Cambridgeshire districts

New or recent migration to an area for employment by non-UK born residents can be crudely assessed by data showing new national insurance registrations. For Peterborough and districts in Cambridgeshire, these data are presented in the figure below as a rate of the total population for years 2010 – 2014.

Figure 11: Non-UK born National Insurance Registrations, Crude Rate Per 1,000 Total Population, 2010 – 2014



Source: Office for National Statistics, 2014, http://www.ons.gov.uk/ons/rel/migration1/migration-indicators-suite/2014/index.html

Cambridge City and Peterborough have the highest rates of NINO registrations by migrants.

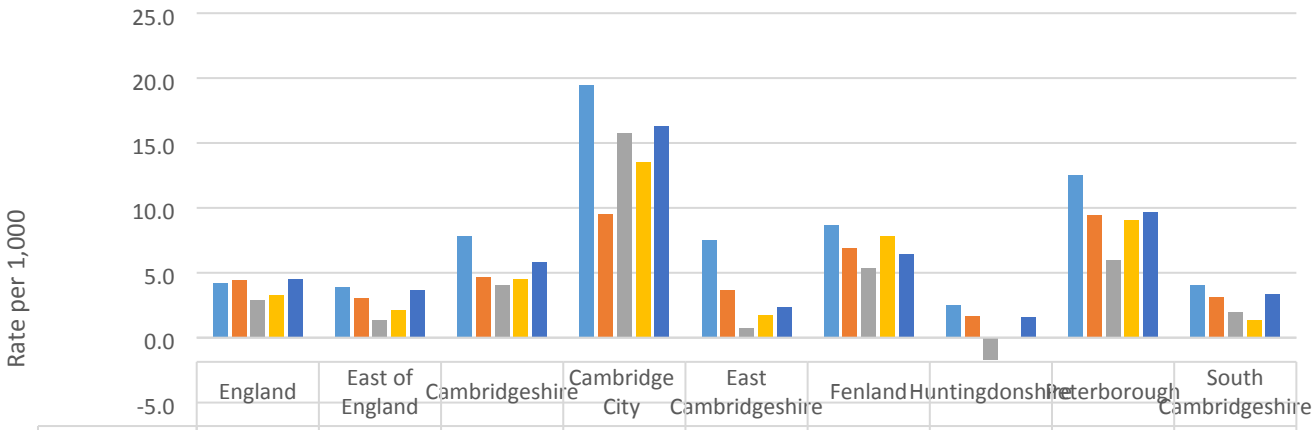
In terms of overall numbers, Peterborough recorded 4,360 NINO registrations in 2014.

Net migration – the difference between emigration and immigration rates across Peterborough and Cambridgeshire

With regards to migration, 'inflow' refers to immigration, 'outflow' refers to emigration and the difference between the two (e.g. the difference between population arriving and leaving) a country is 'net migration'. For example, in 2014, inflows to the UK were 641,000, outflows were 323,000 and net migration was therefore 318,000.

The figure below shows the net migration as a rate per 1,000 population for Peterborough and each Cambridgeshire district, compared with England and the East of England. The rate would be one of several factors that affect the overall population change over time. Both Cambridgeshire and Peterborough have higher rates of long-term international migration than England and the highest rate in the area is in Cambridge City.

Figure 12: Long-term international migration net rate, Crude Rate Per 1,000 Total Population, 2009-2010 to 2013-2014



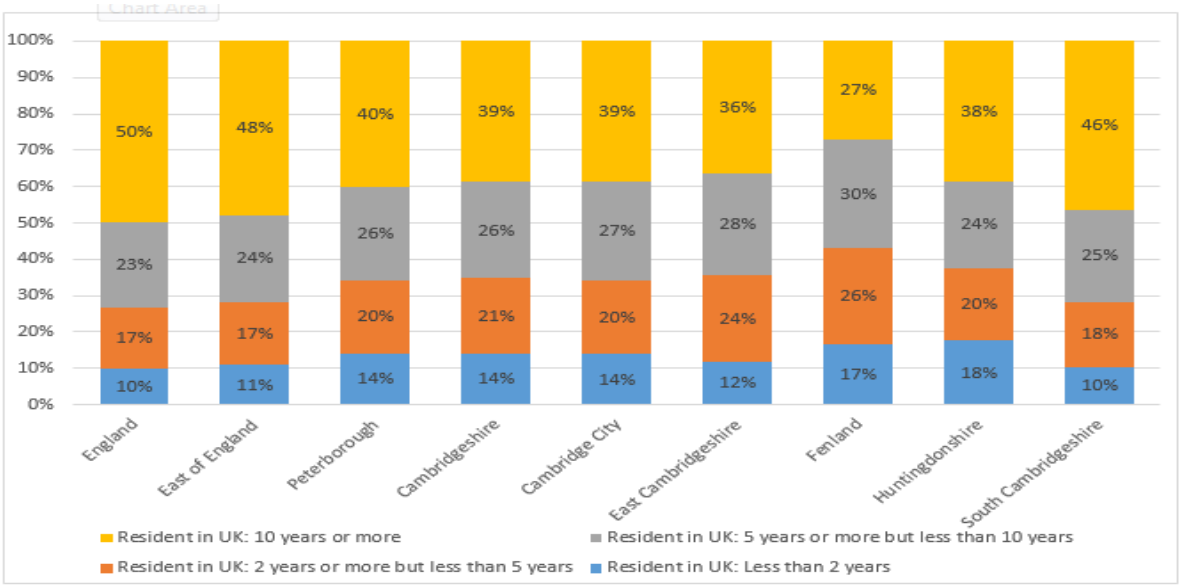
	England	East of England	Cambridgeshire	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	Peterborough	South Cambridgeshire
2009-2010	4.2	3.9	7.8	19.5	7.5	8.7	2.5	12.5	4.0
2010-2011	4.4	3.1	4.6	9.5	3.7	6.9	1.6	9.4	3.1
2011-2012	2.9	1.4	4.0	15.7	0.7	5.4	-1.7	6.0	1.9
2012-2013	3.2	2.1	4.5	13.5	1.8	7.8	0.0	9.1	1.4
2013-2014	4.5	3.6	5.8	16.3	2.3	6.4	1.6	9.7	3.4

Source: Office for National Statistics, 2014, http://www.ons.gov.uk/ons/rel/migration1/migration-indicators-suite/2014/index.html

Length of residence of non-UK born residents in Peterborough and Cambridgeshire

Information on the length of time the non-UK born population has resided in a location indicates how settled they are. The degree of 'settlement' will impact on needs and services in any area. The figure below shows the length of residence in non-UK born migrants in Peterborough and for each area in Cambridgeshire at the time of the 2011 Census.

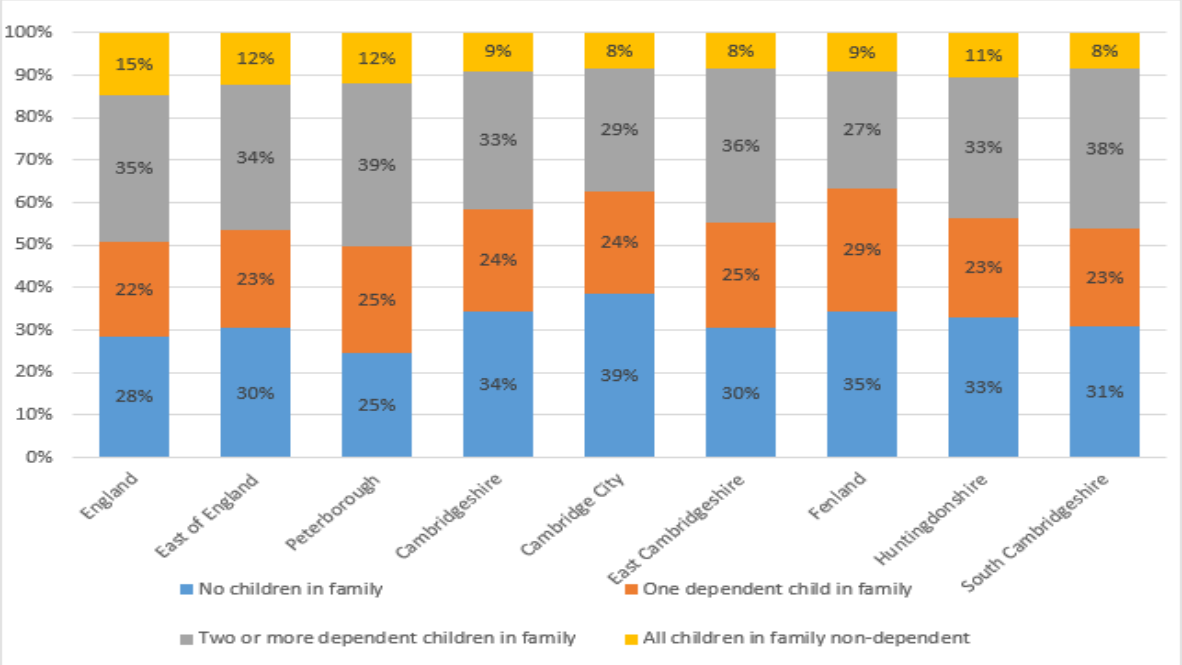
Figure 13: Length of Residence in UK – Non-UK born working population 2011



Source: Census, 2011, https://www.nomisweb.co.uk/census/2011/qs601ew

Data show that in 2011 Peterborough had a higher percentage than England of migrants who have been resident in the UK for 5 years or less and conversely a lower percentage who had been in the UK for 10 years or more.

Figure 14: Number of children born to parents whose original country of residence is not the UK 2011



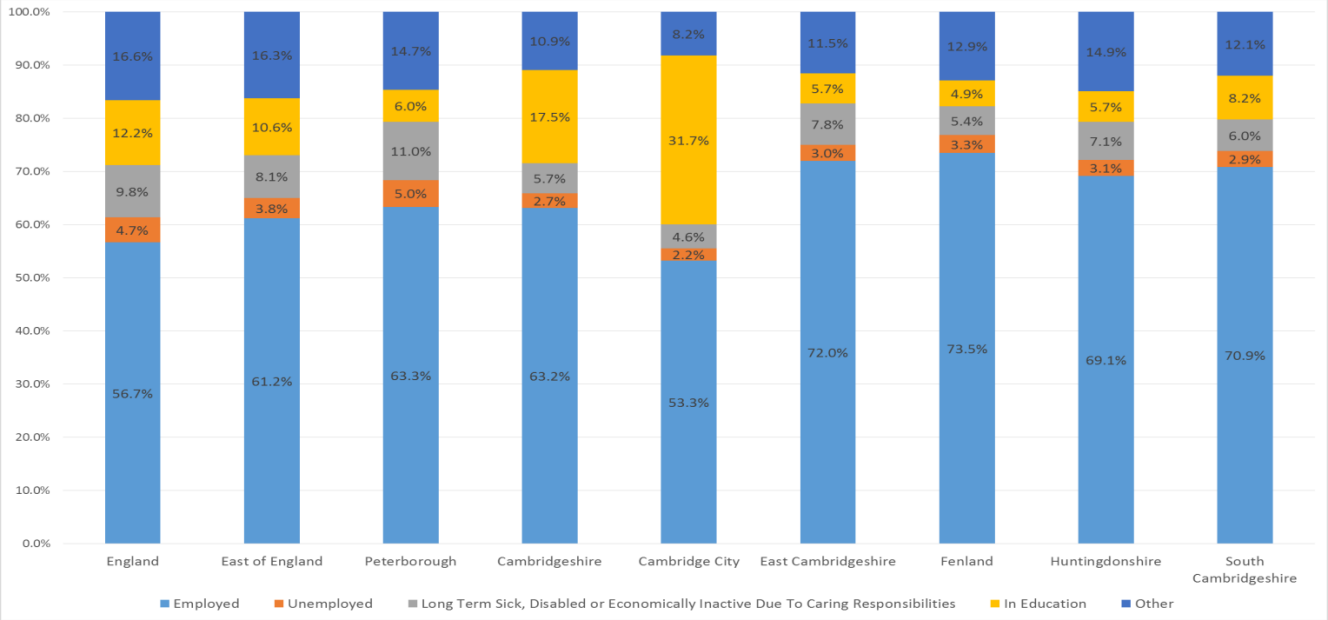
Source: Census, 2011, https://www.nomisweb.co.uk/census/2011/qs601ew

In Peterborough in 2011, 64% of non-UK born residents had one or more dependant children, which is above the national average for non-UK born populations of 57%.

Economic Status of Non-UK Born Residents

The economic status of non-UK born residents provides an indication of the main reasons why migrants may settle in a particular area – for employment or education, for example. The figure below compares information taken from the 2011 census to determine the economic status of non-UK born residents across Peterborough and Cambridgeshire and compares this to England and the East of England.

Figure 15: Economic Status of Non-UK Born Residents, 2011



Source: Census, 2011, https://www.nomisweb.co.uk/census/2011/qs601ew

In 2011, Peterborough had a higher proportion of Non-UK born residents who were employed compared with both England and the East of England and proportionately fewer Non-UK born residents who were in education. This contrasts with Cambridge City where education was a key determining factor in the high rates of migration in Cambridge City, with 31.7% of non-UK born residents responding to the 2011 census stating they were in education[2]. 11.0% of non-UK born residents in Peterborough stated they were economically inactive due to caring responsibilities or to being long term sick or disabled.

[2] Poppleton, S. et al, Social and Public Service Impacts of International Migration at the Local Level, Home Office, July 2013, p. 20

4. Children & Education

Key Findings

- 45% of pupils in Peterborough have an ethnicity stated as 'not White British', (15,285 of 33,930 pupils).
- The most common ethnicities in the 2015 school census, other than 'White British', were 'Any Other White' (5,421 pupils – 16%), Pakistani (4,426 – 13%) and Indian (835 – 2.5%).
- 35.17% of pupils speak a language other than English. Panjabi and Polish are second and third most prevalent languages spoken by children after English.
- There is a wide range between different schools in the proportion of pupils who speak a language other than English at home, depending on the schools location and the communities which they serve.
- In general educational attainment is lower for pupils who speak a language other than English at home, and this is most marked for pupils who speak an Eastern European language. However the improvement in attainment between 2013 and 2015 has also been fastest for pupils speaking an Eastern European language at home.

Introduction

Schools have been identified as locations where 'community cohesion' can be fostered and encouraged,[3] as they are areas in which parents from different communities liaise and where children from differing backgrounds congregate to learn together. However, there remains debate about the levels to which schools should acknowledge diversity between pupils of differing backgrounds and this is an issue of particular significance in areas with fast-growing populations in which growth is partly attributable to relatively high levels of migration, such as Peterborough.

Ethnicity of school pupils across Peterborough

It is difficult to obtain data that directly states whether a pupil is part of the migrant population. Instead, details of a pupil's ethnicity and primary language spoken at home are recorded by the annual school census. This data does not describe whether pupils were born outside the UK or whether their parents are migrants to the UK. Information taken from the annual school census in 2015 is presented below for Peterborough and Cambridgeshire and its districts to compare proportions of pupils who are not 'white British'.

[3] https://www.sussex.ac.uk/webteam/gateway/file.php?name=mwp47.pdf&site=252

Figure 16: Total Pupils with a Stated Ethnicity

Area	Total Pupils	Total Pupils Not 'White British'	% Of Pupils Not 'White British'
Peterborough	33,930	15,285	45.0%
Cambridge City	11,862	5,016	42.3%
East Cambs	11,482	1,698	14.8%
Fenland	12,790	2,157	16.9%
Huntingdonshire	22,471	3,472	15.5%
South Cambs	19,844	3,614	18.2%
Cambridgeshire Districts Total	**78,449***	**15,957**	**20.3%**
Cambridgeshire & Peterborough Total	**112,379***	**31,242**	**27.8%**

Source: Cambridgeshire County Council & Peterborough City Council Education Data, 2015 School Census

* 1,676 pupils in Cambridgeshire and 365 pupils in Peterborough fall within the categories 'information not recorded, information not obtained, refused to provide information'. Overall number of pupils including these categories is 80,125 for Cambridgeshire and 34,295 in Peterborough (114,420 pupils in total).

Peterborough has the largest percentage in the Cambridgeshire and Peterborough area of pupils with a stated ethnicity whose ethnicity is not 'White British', 45.0% (15,285 of 33,930 pupils), although Cambridge City has a similar proportion at 42.3%. The proportion of pupils with an ethnicity stated as not white Bristish is greater than the proportion of the general population that is not white British or white Irish from the 2011 Census data shown in section 1 (45% compared with 28.4%).

The figure on the next page presents a more detailed picture of the ethnic mix of school children in Peterborough, compared with Cambridgeshire districts.

Figure 17: Ethnicity Breakdown (Observed Numbers) of pupils at schools in Peterborough and Cambridgeshire

Area	Any Other Asian	Any Other Black	Any Other Ethnic Group	Any Other Mixed	Any Other White	Bangladeshi	Black African	Black Caribbean	Chinese	Gypsy/ Roma	Indian	Mixed White/Black African	Mixed White/ Black Caribbean	Pakistani	Traveller of Irish Heritage	White and Asian	White British	White Irish	Total
Peterborough	756	189	346	468	5,421	68	744	159	128	291	835	306	538	4,426	31	514	18,645	65	33,930
Cambridgeshire	991	177	608	1,339	6,503	624	534	138	527	507	871	472	712	481	128	1,079	62,492	266	78,449

Source: Cambridgeshire County Council & Peterborough City Council Education Data, 2015 School Census

In Peterborough, the most common ethnicities (where an ethnicity was stated) in the 2015 school census, other than 'White British', were 'Any Other White' (5,421 pupils – 16%), Pakistani (4,426 – 13%) and Indian (835 – 2.5%).

Children who speak a language other than English at home

School census data 2015 records the number of pupils in each school who speak a language other than English at home.

For all schools in Peterborough (34295 pupils), 64.93% speak English at home. 35.17% of pupils speak a language other than English. The languages most frequently spoken by Peterborough school age children are shown in the table below. Panjabi is the second most prevalent language spoken by children after English (at 6.28% of all Peterborough school age children) followed by Polish (4.86%).

Figure 18 – Number and proportion of children who speak English and languages other than English at home – languages with over 2% prevalence are shown

Language	# of Speakers	% of all speakers
English	22269	64.93%
Panjabi	2153	6.28%
Polish	1667	4.86%
Urdu	1499	4.37%
Lithuanian	1184	3.45%
Portuguese	866	2.53%

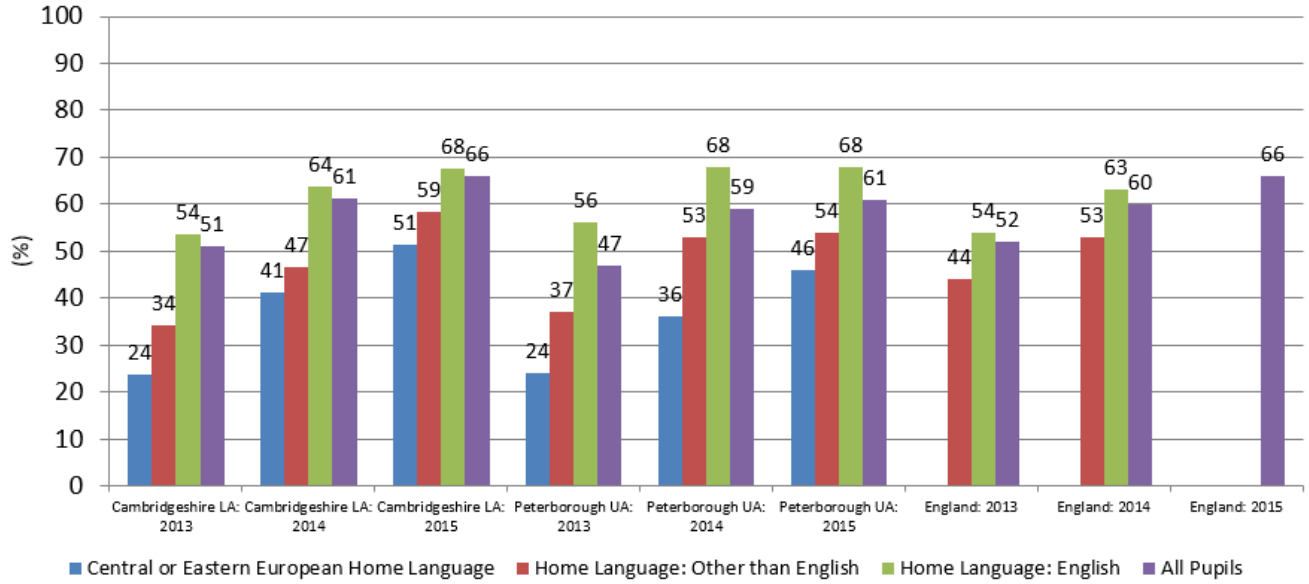
Source: School census data 2015

There is a wide variation between schools in Peterborough in the proportion of pupils who speak a language other than English at home, depending on their location and the communities they serve. Overall 38.6% of primary school pupils speak a language other than English at home, with the proportion attending individual schools varying from under 5% to over 90% of children. Similarly, 29.7% of secondary school pupils speak a language other than English at home, with the proportion attending individual schools ranging from under 5% to 65%.

Educational attainment of pupils assessed in relation to the primary language spoken at home

Data show that in both Peterborough and Cambridgeshire, the percentage of children who primarily speak a home language other than English achieving a good level of development in the early years foundation stage profile is lower than for children who primarily speak English; this is similar to the pattern observed nationally. This is most marked for pupils who speak a central or Eastern European language. In both Cambridgeshire and Peterborough there has been an increase in attainment level over the period shown (from 2013-2015) for pupils who either speak English at home or other languages, with the most marked improvement being for pupils who speak a central or Eastern European language.

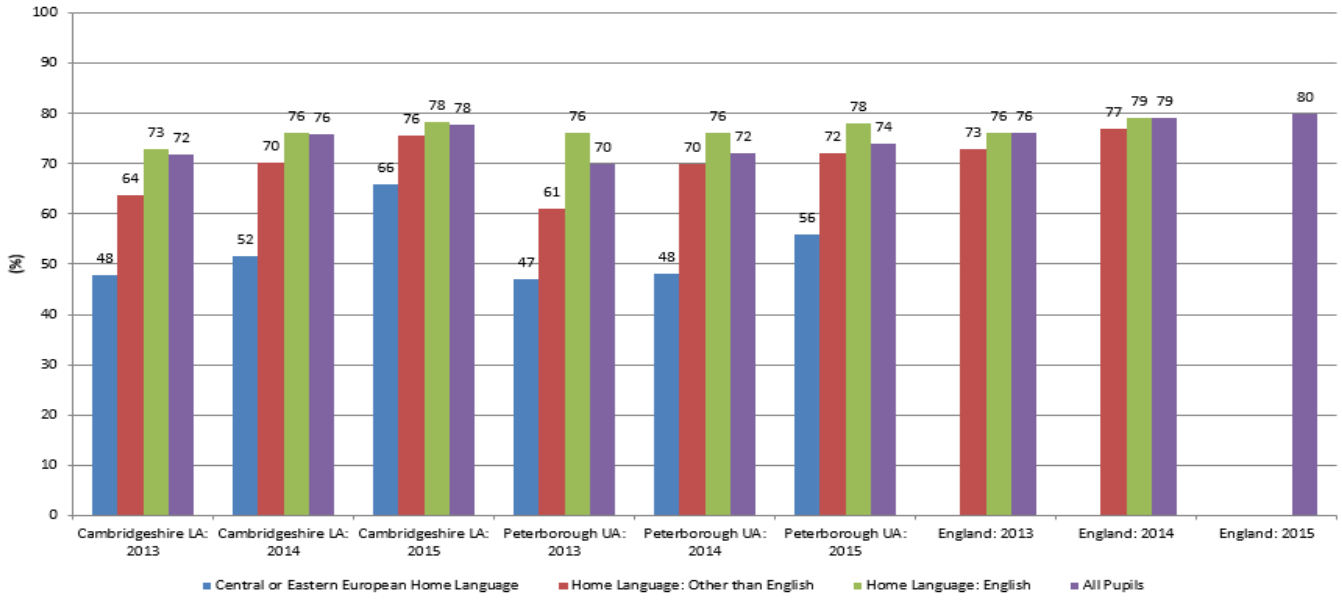
Figure 19: Proportion of Pupils Achieving a Good Level of Development in the Early Years Foundation Stage Profile by Primary Language Spoken at Home , 2013-15



Source: Department for Education, Statistical First Releases

Attainment at Level 4 and above, is lower in primary pupils in Peterborough who speak a central or Eastern European language at home compared with those who speak other languages at home, including English. Primary school pupils who speak other languages than English at home have a lower attainment at Level 4 and above in Key Stage 2 Reading, Writing TA & Mathematics than those who speak English and this is most marked for children who speak a central or Eastern European language. The gap has narrowed in recent years and attainment has increased for the period shown (2013 – 2015) with the greatest improvement seen in pupils who speak Central or Eastern European languages.

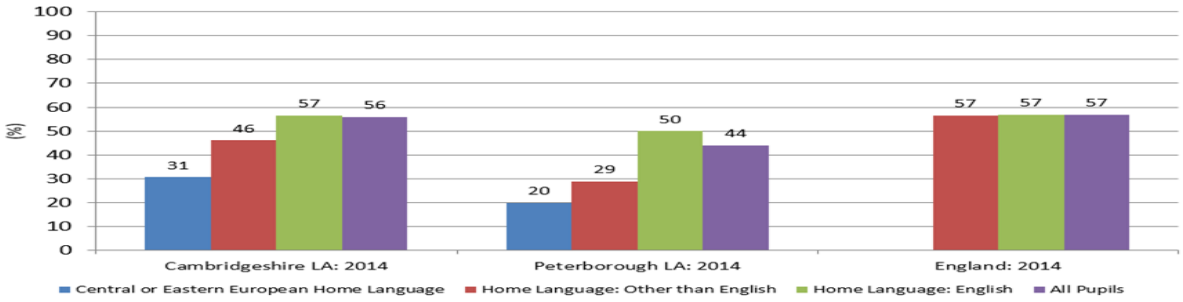
Figure 20: Proportion of Pupils Achieving L4+ in Key Stage 2 Reading, Writing TA & Mathematics, 2013-15



Source: Department for Education, Statistical First Releases

Attainment at the end of secondary school as measured by the proportion of pupils obtaining 5 or more GCSE grades A*-C is considerably lower in pupils in Peterborough who speak a Central or Eastern European language at home or a language other than English, compared with those whose home language is English. However the direct relationship between language spoken at home and educational attainment is difficult to assess, because schools with the highest proportion of pupils speaking a language other than English at home are in some of the most deprived areas and also experience higher levels of 'pupil turnover'. Socio-economic deprivation is independently associated with poorer educational performance.

Figure 21: Proportion of Pupils Achieving 5+ GCSE Grades A*-C, including English & Mathematics



Source: Department for Education, Statistical First Releases

Children in Need

A 'child in need' is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or the child is disabled.[4]

Figure 22: Peterborough Children in Need Referrals Jan 2012 – Aug 2015, 10 Most Common Languages Spoken at Home

Number	Language Spoken At Home	Referrals Number	Referrals % Of Total	Pupils Number	Pupils % Of Total
1	English	4,145	77.9%	22,269	65.1%
2	Lithuanian	233	4.4%	1,184	3.5%
3	Slovak	182	3.4%	442	1.3%
4	Portuguese	154	2.9%	866	2.5%
5	Polish	134	2.5%	1,667	4.9%
6	Latvian	97	1.8%	414	1.2%
7	Czech Republic	66	1.2%	299	0.9%
8	Panjabi	55	1.0%	2,153	6.3%
9	Urdu	45	0.8%	1,499	4.4%
10	Russia	29	0.5%	225	0.7%
-	Other	182	3.4%	3,169	9.3%
-	Total ('Blanks' are excluded)	5,322	100.0%	34,187	100.0%

Source: Peterborough City Council Children in Need Referral Data

4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

The table above shows the 10 primary languages spoken at home for which the highest number of children in need referrals in Peterborough were made between January 2012 and August 2015 and numbers of pupils attending Peterborough schools by language. Data show that, in Peterborough, 77.9% of children in need referrals were for primarily English-speaking pupils, whereas only 65.1% of pupils in the area speak English as a first language. This may be due to 'under-reporting' with regards to children who speak languages other than English; for example, pupils who primarily speak Panjabi represent 6.3% of the pupils in Peterborough but only 1% of referrals.

5. Health

Key Messages -

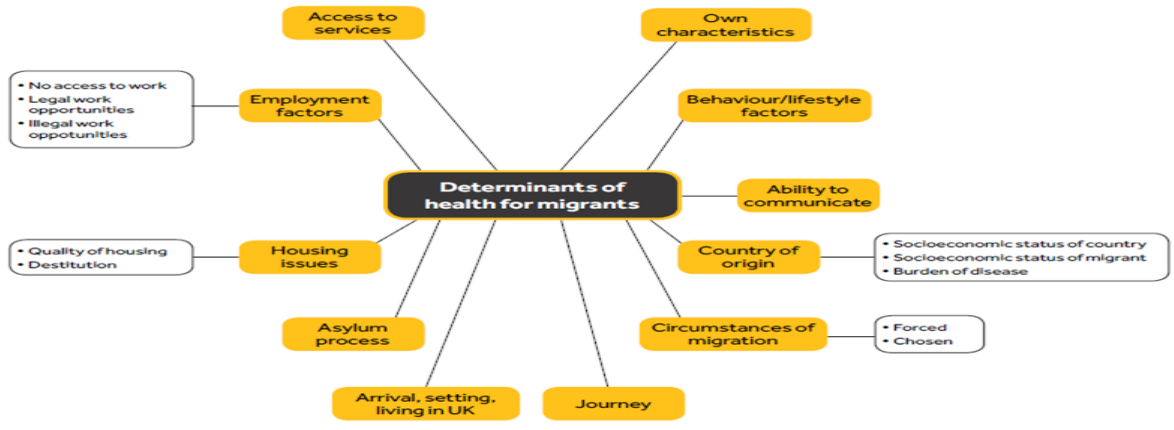
- Some ethnic communities are known through national and international research to have a higher risk of some health conditions and a lower risk of other health conditions than the average for the UK. There are also health risks associated with the relatively higher levels of socio-economic deprivation experienced by some local ethnic communities, and the challenges and stresses associated with being a recent migrant or a refugee.
- Electoral wards in Peterborough with greater proportions of people in BME groups generally have higher rates of overall mortality, and mortality from circulatory disease and coronary heart disease. However, In Peterborough, higher proportions of BME communities live in deprived areas. There is also a strong correlation by electoral ward between income deprivation and mortality rates and emergency hospital admission rates.
- People of Black Caribbean, Indian, Pakistani and Bangladeshi ethnicity have a higher prevalence of diabetes than the general population and black ethnic groups have a higher incidence of stroke for both sexes than the white ethnic groups in the UK
- Although there is no local data that examines the variation in cancer screening uptake by ethnicity, the research literature provides evidence that uptake for cancer screening is lower in some ethnic groups than the general population, including South Asian immigrants having lower rates of breast, cervical and colorectal cancer screening.
- Peterborough is among the areas with higher rates of tuberculosis within East Anglia & Essex. TB in the UK is higher among migrants from countries with high incidence of TB. The highest TB rates in the UK are seen in people with Indian and Pakistani ethnicities. There is also evidence that the highest rates of TB in migrants are in people who are recent arrivals in the UK.
- Sexual health is an area of concern in the migrant population and will need to be explored further to ensure access to services in hard to reach communities. The disparity between a late HIV diagnosis rate of 62% in Peterborough and 49% in Cambridgeshire is worthy of further investigation for its possible effect on the non-UK born population, which data show to be particularly susceptible to both late diagnosis of HIV and subsequent mortality within one year of diagnosis
- The percentage of births to non-UK born mothers was 43.6% of all births in Peterborough in 2014, although there is no further ethnic breakdown of this information. There is national research evidence that women from BME groups who were born outside the UK were later in booking antenatal care, received poorer information about antenatal care and may be less likely to be treated with respect by staff compared to White women born in the UK, although we do not have local research.

- There is a lack of systematically collected data that means our knowledge of ethnic minority and migrants' mental health remains limited. It would be worth investigating whether local NHS mental health are suitable and accessible to these populations.
- Suicide rates are higher in all of the EU A8 countries compared to England and there is some evidence that the suicide rate of Eastern European migrants living in Peterborough is also higher than would be expected.
- There are increasing indications that the prevalence of dementia in Black AfricanCaribbean and South Asian UK populations is greater than the white UK population and that the age of onset is lower for Black African-Caribbean groups than the white UK population
- Over the 10 years 2003/04 - 2013/14, new migrant GP registrations have risen by 37.6% in England. In Peterborough, the increase over this time period has been 71.6%.
- Peterborough has the second highest recorded rate of new migrant GP registrations across the Eastern region - over double the East of England rate and England rate

Introduction

The healthcare needs of non-UK born residents may be influenced by a range of factors - not only language and cultural differences but also the burden of disease and living conditions in their country of origin, experiences during migration, their circumstances in the UK and other factors relating to ethnicity and cultural practices. Recent studies have found that the majority of migrants are young and healthy on arrival, but their health – particularly their mental health – declines sharply after arrival in a new country, as a result of a range of factors that may include social exclusion, poverty and low standards of accommodation[5]. It is therefore important to consider the wider circumstances of migrants' lives in making sense of patterns of health and health care.

Figure 23: Health and wellbeing determinants of Migrants



Source: Rose, N., Stirling, S., Ricketts, A., & Chappel, D. (2011). Including Migrant Populations in Joint Strategic Needs Assessment. A Guide.

Health impacts relating to country of origin

[5] Collis, A. et al, Migrant Health Scoping Report, East of England Regional Assembly (2009), p. 7

Although migrants, being usually relatively young and in reasonable health, do not necessarily have a similar health profile to that of the population from which they have emigrated, analysis of mortality data in the countries of birth or origin represented by the main migrant and ethnic communities in Peterborough (figure 24 below) can be useful in assessing whether there are links between intrinsic factors, lifestyle behaviours and mortality outcomes which place some communities at higher risk. Mortality rates within a country will be influenced both by the likelihood that people develop an illness, and by the local availability and quality of healthcare for that illness.

Figure 24: Causes of Death – Directly Age-Standardised Rate per 100,000 population, All Ages, 2012

Country	Diabetes	Cardio-vascular disease	Liver cirrhosis (male mortality only)	Cancer	Respiratory disease	Suicide
Bangladesh	29.8	166.2	29.1	87.8	106.7	7.8
India	26.3	306.3	39.5	71.9	154.8	21.1
Pakistan	42.5	274.2	37.4	88.3	91.4	9.3
China	14.9	300	9.9	143.4	77.1	7.8
Jamaica	71.7	232.6	9.8	122.8	16.6	1.2
Nigeria	47	266.5	79.2	106.7	36.8	6.5
Portugal	17.6	113.1	20	130	22	8.2
Poland	9.4	253.4	28.8	149.7	20.8	16.6
Czech Republic	11.1	239	23.7	142.2	15.4	12.5
Hungary	12.3	293.3	57	184	27.2	19.1
Estonia	5.5	272.1	21.8	142.4	9.5	13.6
Latvia	20.8	361.1	29.1	157.2	8.8	16.2
Lithuania	4.7	322.5	53.9	143	11.8	28.2
Slovakia	6.7	305.9	39.3	139.6	13.2	10.1
Slovenia	3.6	141.2	41.9	150.7	11	12.4
UK	4.2	111.8	16	130.4	30.5	6.2

Source: World Health Organisation

Note: Nigeria was used as a reference for communities with Black African ethnicity and Jamaica was used as a reference for communities with Black Caribbean ethnicity. There is no specific data that determines the country of origin for the black ethnic communities and these were chosen as a result of research on historical migration to the UK.

Red cells in the table above represent a mortality rate at least double that of the UK. Green cells represent mortality rates below those of the UK.

Some main points from the table above:

- Diabetes in Pakistan causes age-standardised mortality rates ten times higher than the UK.
- Diabetes causes extremely high mortality rates in Jamaica and this may have an implication for communities with black Caribbean ethnicities.
- Mortality from cardio-vascular disease is higher in all countries listed than in the UK, with comparatively high rates in both Asian and Eastern European countries.

- Mortality from liver Cirrhosis in males is extremely high when compared with the UK, in Nigeria, Hungary and Lithuania
- Cancer mortality rates are lower in the south Asian countries, Nigeria, Jamaica and Portugal compared to the UK
- Mortality from respiratory disease is high in the Asian countries listed
- Mortality rates from suicide are higher in all countries listed compared to the UK, but are particularly high in Lithuania and India

Any link between ethnic origin or country of birth and risk of disease is explored further in the sections that follow.

Inequalities within Peterborough – mortality rates by electoral ward

The figure below shows the six Peterborough wards with the highest proportion in the population of BME ethnicities and compares overall mortality rates, mortality from circulatory disease and coronary heart disease. It also lists emergency and elective hospital admission rates for these wards.

It is clear, with the exception of West ward, that there is an association between higher rates of overall mortality, mortality from circulatory disease and coronary heart disease in wards with greater proportions of people in BME groups. It is also interesting that emergency hospital admissions are higher than the Peterborough average for these wards but elective (planned) admission rates are lower. This data does not directly link mortality risk and risk of emergency admission to ethnicity, but simply highlights the association in these wards. There is also a strong correlation between income deprivation and mortality rates and emergency hospital admission rates and these wards have high levels of deprivation (apart from West ward) – see Demography section. Deprivation is associated with risk factors for cardiovascular disease, including smoking prevalence, obesity and physical inactivity.

Figure 25 – Peterborough wards with the highest proportion of BME communities showing all cause mortality rates, mortality from circulatory disease, coronary heart disease and rates of emergency and elective hospital admissions

Electoral Ward	BME Population (%, 2011)	Deaths, U75, All Causes (SMR, 2008-2012)	Deaths, U75, Circulatory Disease (SMR, 2008-2012)	Deaths, U75, Coronary Heart Disease (SMR, 2008-2012)	Emergency Hospital Admissions for all Causes (SAR, 2008/09 - 2012/13)	Elective Hospital Admissions for all Causes (SAR, 2008/09 - 2012/13)
Central	58.2	150.6	172.1	229.9	127.5	89.9
Park	35.8	142.3	200.8	212.6	119.3	89.7
Ravensthorpe	30.8	159.2	224.5	262.0	123.1	95.8
West	29.5	87.7	86.5	62.3	92.8	89.1
East	26.8	142.9	181.2	188.9	114.4	92.3
North	23.0	129.5	137.4	161.5	117.4	98.5

Red indicates rates higher than Peterborough average and green indicates rates lower than Peterborough average.

Cardiovascular disease (CVD) and ethnicity

Peterborough CVD JSNA 2015 contains a section describing risk of cardio-vascular disease associated with ethnicity - Source: https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/healthcare/public-health/CardiovascularDiseaseJSNA-November2015.pdf?inline=true

It refers to data from the British Heart Foundation that shows a disparity between ethnicities in prevalence of CVD and in associated risk factors. Black Caribbean, Indian, Pakistani and Bangladeshi men have a higher prevalence of diabetes than the general population and black ethnic groups have a higher incidence of stroke for both sexes than the white ethnic groups (British Heart Foundation, 2010[6]), while South Asian groups have a higher incidence of coronary heart disease.

Determining risk factors associated with ethnicity for cardiovascular disease is complicated as there are potentially many confounders including genetics, cultural and social practices and levels of obesity. There is however evidence that inequalities exists between ethnicities with regard to access to treatment, (Heart UK, 2013[7]) as well as behavioural factors such as smoking, diet and physical activity.

Hospital admissions data for Cardiovascular disease is available for Peterborough and broken down by ethnicity (Peterborough CVD JSNA 2015). This shows no increase incidence of admissions for CVD in the BME ethnicities compared with the white British community. However, there is a high proportion of ethnicity described as 'not known' in the data which is likely to make the results unreliable.

Diabetes and ethnicty

As stated in the CVD JSNA, 2015, ethnicity is a risk factor for diabetes. People with a South Asian ethnicity have a 50% higher lifetime risk of developing type 2 diabetes than white Europeans. Diabetes in these groups can often occur at a younger age and in people with a lower Body Mass Index (BMI). Obesity and diabetes guidelines take account of this, by recommending services for weight management to those with South Asian ethnicity and lower BMI, in order to help prevent the development of diabetes or to help reverse new onset diabetes (NICE Guidelines for Obesity Management, 2015[8]).

Deprivation is also associated with risk of developing diabetes as deprived communities have higher levels of obesity and physical inactivity, which in turn are risk factors for developing type 2 diabetes. In Peterborough, higher proportions of BME communities live in deprived areas.

Diabetes is also a strong risk factor for developing cardiovascular disease. Adults with diabetes are 2 to 4 times more likely to have heart disease or a stroke than people without diabetes.

Variation in Cancer incidence, survival and screening uptake in ethnic communities

Mortality from Cancer 2014.

The World Health Organisation (WHO) estimates that in 2012, about 8.2 million deaths, or 13% of all global deaths, were attributable to cancer. The UK recordend 163,200* deaths from Cancer in 2014 with equates to a crude mortality rate of 259.9 per 100,000 population. Of the counties with a high preveleance in Peterbough, Estonia, Slovenia and Latvia all had a higher crude rate of mortality from Cancer in they respective home counrties when compared to the UK.

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[6] https://www.bhf.org.uk/-/media/files/research/heart-statistics/hs2010fc_ethnic_differences_in_cardiovascular_disease-full-copy.pdf

[7] https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=0ahUKEwjXnJ_SqevOAhXEDxoKHb2VAkYQFgg0MAM&url=https%3A%2F%2Fheartuk.org.uk%2Ffiles%2Fuploads%2FBridging_the_Gaps_Tackling_inequalities_in_cardiovascular_disease.pdf&usg=AFQjCNEKMGQdVk2HR_NRJ6eUMzhuJFQALA&bvm=bv.131286987,d.d2s

[8] https://www.nice.org.uk/guidance/Cg43

Variation in cancer incidence by ethnicity – evidence from the literature

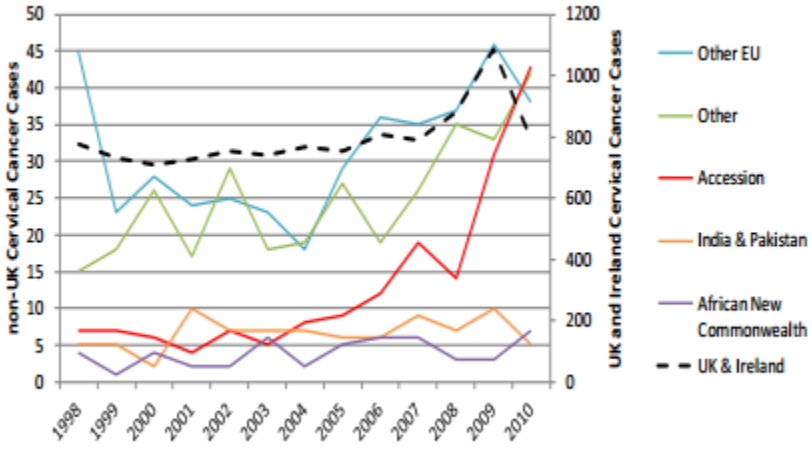
BME groups have lower risk of cancer in general than people of white ethnicity (Cancer Incidence and Survival By Major Ethnic Group, England, 2002-2006[9] & National Cancer Intelligence Network, 2015[10] Evidence shows that people of Asian, Chinese and mixed ethnic groups have significantly lower risk of cancer than those of white ethnicities if 'all malignancies combined' are analysed. Black females have a 10% - 40% lower risk of cancer than white females but the risk of cancer in Black males is similar to White males.

However, for specific cancers, the risk varied for different ethnic groups. The risk of liver cancer is 1.5 to 3 times greater for Asian ethnicities compared with White ethnicities. Cancer of the mouth was significantly increased for Asian females. The risk of cervical cancer is significantly higher in Asian and black females, for those aged 65 and over, but lower in Asian females below the age of 65, when compared with white females. Black males were more likely to have a diagnosis of prostate cancer than White males. Both males and females from the Black ethnic group also had higher rates of cancers of the stomach and liver as well as myeloma.

Asian and black ethnicity lowers the risk for breast, prostate, lung and colorectal cancer, and less common cancer types including cancers of the bladder, brain and CNS, kidney, oesophagus, ovary, pancreas and malignant melanoma of the skin.

The effect of new migration on incidence of cervical cancer in Engand is shown in the figure below. There has been a recent increase in cases of cervical cancer in people migrating to the UK from EU and Accession countries (including the A8 countries).

Figure 26 – Cervical cancer cases in non-UK born women by country of origin, England 1998-2010



Reference: Investigating the effect of immigration on trends in cervical cancer in young women, Rebecca Elleray, Jason Poole, Jack Hales PHE Knowledge & Intelligence Team (East Midlands)

Variation in cancer survival by ethnic group

Cancer survival by ethnicity was also analysed in this report and found that both Black and Asian women aged 15-64 years had reduced survival from breast cancer than women from the White ethnic group at three years (89% and 91%, respectively). In contrast, Asian people and males with lung cancer from the Black ethnic group aged over 65-99 had improved outcomes for lung cancer at both one and three years than White etnicities for all ages.

[9] http://publications.cancerresearchuk.org/downloads/Product/CS_REPORT_INCSURV_ETHNIC.pdf
[10] http://www.ncin.org.uk/cancer_type_and_topic_specific_work/topic_specific_work/equality

Cancer screening

Although there is no local data that examines the variation in cancer screening uptake by ethnicity, the research literature provides evidence that uptake for cancer screening is lower in some ethnic groups than the general population, with people born in South Asia having low rates of breast, cervical and colorectal cancer screening (Szczepura *et al*. 2008[11], Lee *et al*. 2010a[12], Lofters *et al*. 2010[13])

Research indicates that colorectal cancer screening uptake within the South Asian population in England is approximately half that of the general population (33 % vs 61 %), and varies by Muslim (31.9 %), Sikh (34.6 %) and Hindu (43.7 %) faith background. (BMC Public Health, 2015 [14] & Szczepura et al. 2003.[15]) It has also been shown that bowel and breast screening rates remain low for people of South Asian ethnicity, after adjusting for deprivation (Szczepura et al, 2008(1)[16]).

It has been recommended that local language broadcasts on ethnic media and face-to-face approaches within community and faith settings should be developed to increase awareness of colorectal cancer and screening, and address challenges posed by written materials (Szczepura et al, 2008(2)). This could be useful for enhancing bowel screening programmes locally that focus on hard to reach ethnic groups.

Cancer awareness in ethnic groups

There is evidence that awareness of cancer warning signs is low across all BME ethnic groups with lowest awareness in the African group. Women identified more emotional barriers and men more practical barriers to help seeking, with considerable ethnic variation (Waller, 2009[17]). The study suggests the need for culturally sensitive, community-based interventions to raise awareness and encourage early presentation.

Obesity and physical activity

Obesity, risk of obesity and obesity-related disease is different in different ethnic groups with some black and Asian populations showing increased risk for obesity and related disease compared with white British groups. (NOO Ethnicity and Obesity, 2011[18])

Research has shown that south Asian and black ethnicity is a predictor of obesity related behaviours among children in the UK and this cannot be explained by deprivation (Falconer et al, 2014[19])

There is consequently a need to develop culturally specific lifestyle interventions including assessments of dietary factors to reduce obesity-related health inequalities. This should be taken into account when designing lifestyle services to help tackle obesity in children and adults within Asian and black communities in Peterborough.

[11] http://www.ncbi.nlm.nih.gov/pubmed/18831751
[12] http://onlinelibrary.wiley.com/doi/10.1111/hsc.12208/full#hsc12208-bib-0042
[13] http://onlinelibrary.wiley.com/doi/10.1111/hsc.12208/full#hsc12208-bib-0047
[14] http://www.ncbi.nlm.nih.gov/pubmed/26423750 , doi: 10.1186/s12889-015-2334-9
[15] http://wrap.warwick.ac.uk/133/1/WRAP_Szczepura_ethnicity-finalreport.pdf
[16] http://www.biomedcentral.com/qc/1471-2458/8/346
[17] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2790704/
[18] http://www.hscic.gov.uk/catalogue/PUB13219
[19] http://bmjopen.bmj.com/content/4/1/e003949.full

The increased risk of obesity-related disease in some ethnic groups is acknowledged in NICE guidance, (Obesity in children, young people and adults, 2014[20] & NICE guideline PH46, 2013[21]

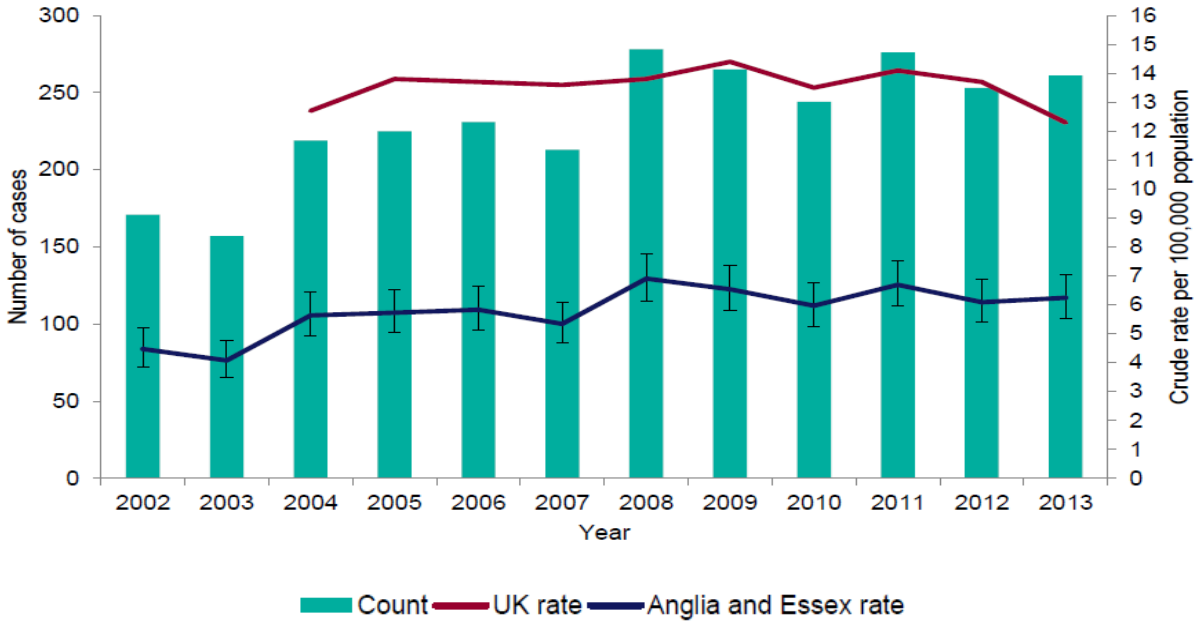
which recommend reducing the definition of obesity and the threshold for obesity services for people with a black, black Caribbean or south Asian ethnicity from BMI of 30 to BMI of 27.5. This would have an impact on weight management services in areas of Peterborough with higher proportions of people from these ethnic backgrounds. It will be important to ensure access to the relevant services for people from Asian and black ethnicities in general practices with higher proportions of people from these backgrounds.

Participation in physical activity has been shown to differ between ethnic groups, for example, Indian, Pakistani, Bangladeshi and Chinese women are all less likely than white women to meet recommended guidelines for physical activity. (Higgins et al, 2012)[22]

Communicable Diseases in the Migrant and ethnic population

Tuberculosis

Figure 27: Tuberculosis case reports and crude rates in Anglia and Essex Public Health England Centre, 2002-2013



Source: PHEC Anglia & Essex Tuberculosis Annual Report May 2015

In 2013, 261 cases of tuberculosis were reported among residents of East Anglia and Essex, a rate of 6.2/100,000 population which is approximately half of the UK rate of 12.3/100,000. 58 of these cases were within Peterborough. Data from the Health Protection Agency show that the majority of observed cases of tuberculosis reported in the UK in recent years were born abroad (74% of the total in 2010[23]). The highest rates of tuberculosis in the UK are in ethnic minority groups and of non-UK born cases diagnosed in 2010, 77% were diagnosed more than two years after arrival in the UK.

[20] https://www.nice.org.uk/guidance/cg189
[21] https://www.nice.org.uk/guidance/ph46/chapter/introduction-scope-and-purpose-of-this-guidance
[22] https://www.ukdataservice.ac.uk/use-data/data-in-use/case-study/?id=97
[23] Health Protection Services. Migrant Health: Infectious diseases in non-UK born populations in the United Kingdom. An update to the baseline report (2011) p.33

The figure below shows annual tuberculosis rates and trends by local authority area across Anglia and Essex. Peterborough is shown to have the highest rate of TB of local authority areas across Anglia and Essex.

Figure 28: Annual tuberculosis case rates by upper tier local authority, Anglia & Essex PHEC, 2002-2013

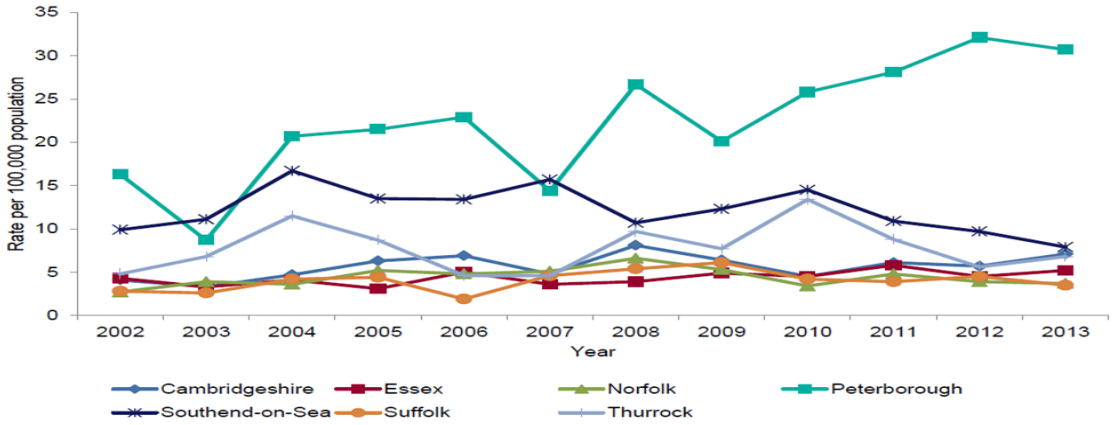
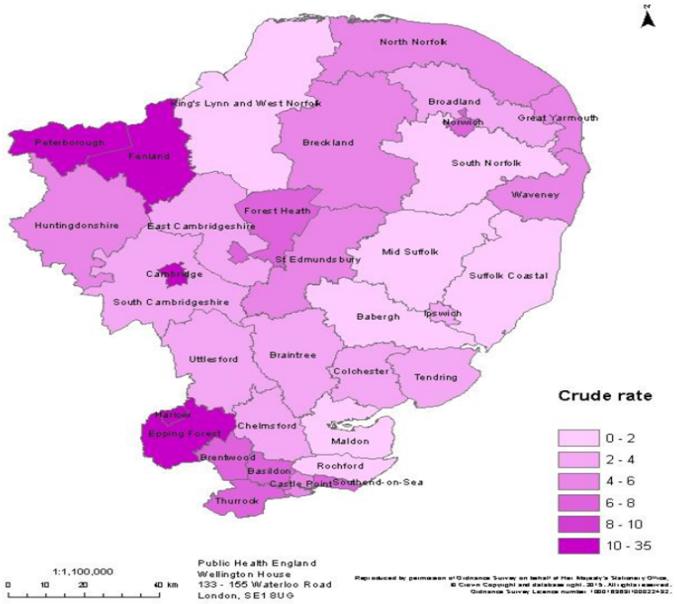


Figure 29: Tuberculosis case rate per 100,000 population for local authorities within Anglia and Essex PHEC, 2013



Source: PHEC Anglia & Essex Tuberculosis Annual Report May 2015

As of May 2012, the UK Home Office replaced the previously-enforced system of active TB case finding at ports of entry in to the UK with 'pre-entry TB screening' prior to migrants applying for a VISA to enter the UK. Everyone who applies for a UK via for more than 6 months and who is resident in a country where TB is common (over 40 incidences per 100,000 population) is now screened for pulmonary tuberculosis at one of the UK approved TB screening centres.[24] TB rates for countries with the highest prevalence are noted in the table below:

[24] https://www.gov.uk/guidance/tuberculosis-screening

Figure 30: Estimated Tuberculosis Rates per 100,000 Population, 2014, in countries with highest ethnic representations in Peterborough

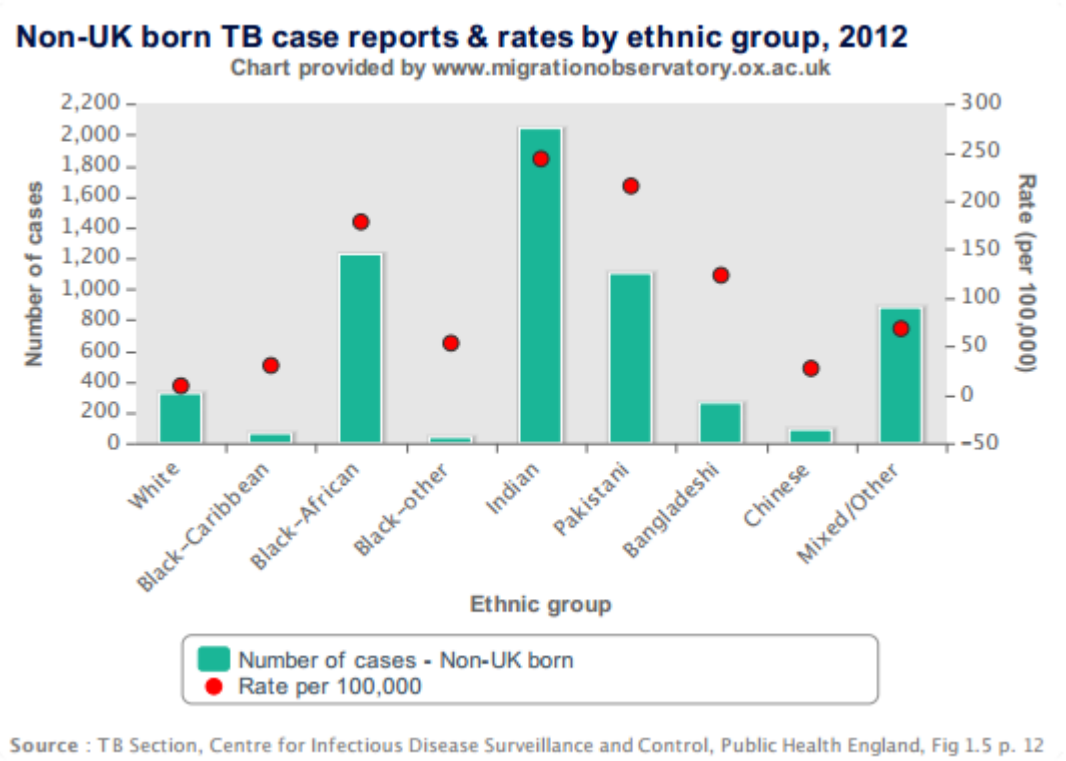
Country	Estimated TB rate per 100,000 population
Pakistan	270
India	167
Lithuania	62
Latvia	49
Portugal	25
Poland	21
Estonia	20
England	13.5
Hungary	12

Source: UK Government, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/491527/WHO_estimates_of_tuberculosis_incidence_by_country__2014_v2.pdf

The figure below shows incidence and rates of Tuberculosis in the non-UK born population in the UK. The highest TB rates are seen in people with Indian and Pakistani ethnicities. There is also evidence that the highest rates of TB in migrants are in people who are recent arrivals in the UK, possibly reflecting prevalence rates in countries of origin. Reactivation of latent Tuberculosis contributes to the overall Tuberculosis numbers and this may be influenced by contributory factors, such as low income and poor living conditions experienced by new migrants in the UK (Robinson and Reeve 2006 – Neighbourhood Experiences of New Immigration: Reflections from the evidence base)[25].

[25] Robinson, D. & Reeve, K. (2006) Neighbourhood Experience of New Immigration – Reflections From the Evidence Base, Joseph Roundtree Foundation

Figure 31: Non-UK born TB Case Reports & Rates by Ethnic Group, 2012



Source : TB Section, Centre for Infectious Disease Surveillance and Control, Public Health England, Fig 1.5 p. 12

Screening for Tuberculosis in BME migrants in Peterborough

A recent Latent Tuberculosis plan for Peterborough and Cambridgeshire has been implemented and intends to screen 350 new migrants, prospectively through selected general practices. New migrants from countries with high incidence of Tuberculosis will be offered screening for latent Tuberculosis upon registration with a participating general practice.

In adition, an education programme targeted at GPs and communities will raise awareness of latent Tuberculosis in higher risk migrant groups.

Tuberculosis Treatment

Public Health England compares treatment services for tuberculosis across the Anglia and Essex region and gives an indication of numbers of patients completing treatment .Peterborough has the highest observed number of people with tuberculosis completing treatment as measured within the Anglia and Essex area for 2012. The percentage of people completing treatment in Peterborough (81.0%) is also higher than the collective percentage for Anglia and Essex (76.0%).

<u>Sexual Health and HIV</u>

New migrants are at higher risk of sexual health problems. Migration alone can result in the end of relationships, new relationships being formed and higher-risk sexual behaviour, increasing the risk of developing sexually transmitted diseases (Burns et al 2008[26], Burns et al 2011[27]). Alcohol is often a

[26] Burns, F. et al (2008) Increase attendances of people of Eastern European origin at sexual health services in London, Sex Transm Infect 2009; 85: 75-78 doi: 10.1136/sti.2007.029546

[27] Burns, F. et al (2011) Sexual and HIV risk behaviour in Central and Eastern European Migrants in London, Sex Transm Infect 2011 Jun: 87(4) 318-24 doi 10.1136/sti.2010.047209

factor in unsafe sex and therefore the spread of sexually transmitted diseases and unplanned pregnancy. Data from the Public Health England HIV and Aids New Diagnosis database shows that the national rate of new HIV diagnoses per 100,000 population was 13 whereas in Anglia and Essex the rate was statistically significantly lower than England at 9 per 100,000.[28] Nationally there are data available which indicate that between 2001 and 2010:

- 65% of new HIV diagnoses where country of birth is known were among those born abroad.
- Heterosexuals who were born outside of the UK were more likely to be diagnosed late compared to those born in the UK (63% compared to 50%).
- Sub-Saharan Africa was the predominant region of birth for HIV amongst heterosexuals. Europe was the most common world region of birth for HIV in homosexual men
- People receiving a 'late' diagnosis of HIV (CD4 count <350 cells/mm3 at time of diagnosis) have a ten-fold increased risk of death within one year of diagnosis compared to those diagnosed promptly.

Immunisation and Vaccine Preventable Diseases

Figure 32: Incidence rate of Measles & Rubella reporting per 1,000,000 population, By countries with highest representation in migrants to Peterborough, January – December 2014

Country	Incidence Rate Per 1,000,000 Population	
	Measles	Rubella
Czech Republic	20.8	-
Estonia	-	-
Hungary	-	-
Latvia	17.6	0.5
Lithuania	3.7	-
Poland	2.9	154.3
Portugal	-	0.7
Slovakia	-	-
Slovenia	25.1	-
UK	2.2	-
World	17.8	7.2

Source: World Health Organisation EpiData, http://www.euro.who.int/__data/assets/pdf_file/0004/276115/EpiData-No12-2014.pdf?ua=1

Data from the World Health Organisation suggest that the incidence rate of Measles is higher in the Czech Republic, Latvia, Poland and Slovenia than the UK and the incidence rate of Rubella is higher in Latvia, portugal and particularly in Poland than England. The data should be treated with a degree of caution due to the number of countries that have not reported an incidence rate.

Maternal health

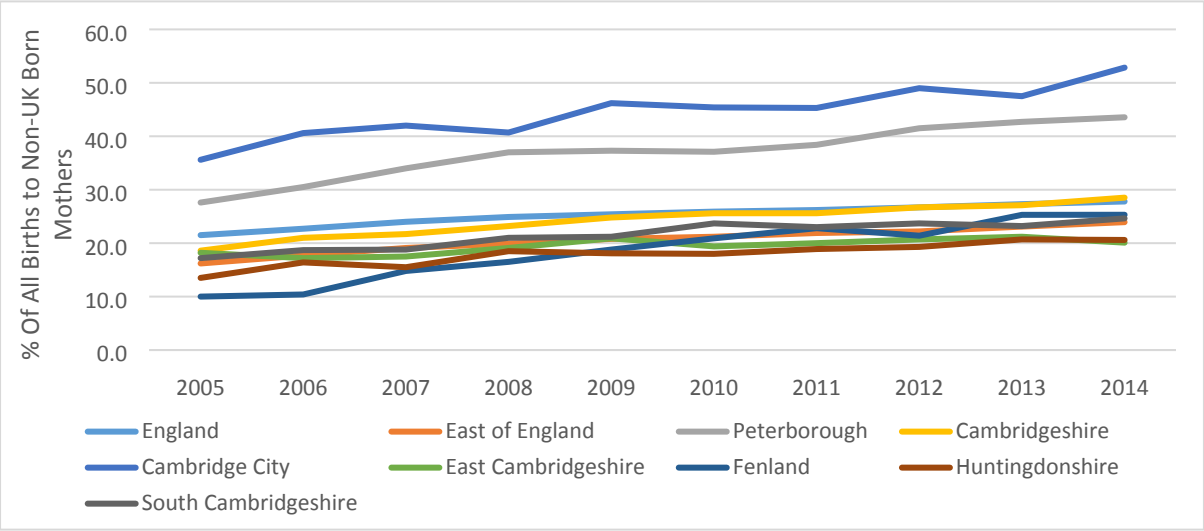
Births to non-UK born mothers

Non-UK-born residents tend to arrive in the UK as people of young working age (section 2) – a similar age group to people who will be having children in the general population. The percentage of

[28] Public Health England, Annual Epidemiological Spotlight on HIV in Anglia and Essex, 2013, URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/359662/Anglia_and_Essex_FES_STI_report_FINAL.pdf

births to non-UK born mothers (figure 33 below) is consequently higher than the proportion of non-UK born residents in the population. This needs to be reflected in the planning and delivery of maternity services.

Figure 33: % of All Births to Non-UK Born Mothers by Area, 2005-2014



Source: Office for National Statistics, Vital Statistics: Population & Health Reference Tables, URL: http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/vitalstatisticspopulationandhealthreferencetables

The percentage of all births to non-UK born mothers has risen in England between 2005 and 2014, from 21.5% of all births to 27.8%. In Peterborough, the percentage has risen from 27.6% in 2005 to 43.6% in 2014 across this time period. As seen in the table above, Peterborough has had a higher percentage of births to non-UK born mothers than England in all years 2005-2014. The data does not provide information to describe the proportion of births by country of origin, but provides an indication of the impact on maternity and children services by the non-UK born population as a whole.

Antenatal care in migrant and BME communities – evidence from national research

There is national evidence that women from BME groups who were born outside the UK were later in booking antenatal care, received poorer information about antenatal care and were less likely to be treated with respect by staff compared to White women born in the UK (Redshaw and Heikkila 2010[29]). Another study showed that 7.1% of non-UK born mothers had no antenatal care at all, compared to 2.4% of mothers born in the UK. The Confidential Enquiry into Maternal Deaths (2006 - 2008[30]) showed that Black African mothers, many of whom were recent migrants including refugees and asylum seekers, had a mortality rate nearly four times that of White women (Lewis 2011[31]). Key risk factors for maternal mortality included lack of antenatal care or late booking. There was also little or no English fluency among a fifth of mothers who died, and inadequate interpretation support from maternity services. There were particularly high proportions of mothers having no antenatal care among Pakistani and Bangladeshi migrant mothers.

[29] https://www.npeu.ox.ac.uk/downloads/files/.../Maternity-Survey-Report-**2010**.pdf

[30] https://www.npeu.ox.ac.uk/mbrrace-uk/reports

[31] Lewis, G., ed. "Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer 2006-2008." Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom (CEMACH), BJOG 118, supp. 1 (2011): 1-203

However, the risk of having no antenatal care is most strongly associated with socio-demographic factors such as younger age, lower educational level,occupational class and living in an electoral ward where at east 30% of the population were from BME communities. (Jayaweera and Quigley 2010[32]).

Mental Health

Mental health and migration

It is known that new migrants are at risk of poor mental health. Factors that increase risk of mental health problems include experiences in the migrants' home countries, stresses of immigration, settling and adaptation to a new country and culture, isolation, stress and poor living conditions (Tobi et all, 2010[33]). The diagram below summarises the range of factors and sub-factors that influence migrant mental wellbeing.

There is a lack of systematically collected data that means our knowledge of migrants' mental health remains limited. It would be worth further investigating whether local mental health services are suitable and accessible to the migrant population.

Figure 34: Factors and sub-factors that influence migrant mental wellbeing

Source: adapted from World Health Organisation, 2002 and Collis et al 'Workers on the Move 2' (Keystone Development Trust)

Mental health issues are likely to be more apparent among vulnerable migrant population groups such as asylum seekers, refugees and women and children who have suffered physical and/or sexual abuse. Evidence from both the UK and across Europe suggests that rates of depression and anxiety are higher among asylum seekers compared to the both the general population and other migrant categories; a rare quantitative study of women internally or internationally trafficked for sex work or

[32] http://www.ncbi.nlm.nih.gov/pubmed/20624665
[33] Tobi, P. et al (2010) Health and Social Care Needs Assessment of Eastern European (including Roma) individuals living in Barking and Dagenham, Institute for Health and Human Development

domestic service found that 70% had experienced both physical and sexual abuse during trafficking and the majority exhibited severe physical and mental health issues as a result[34].

Ethnicity and mental health

The table below provides a breakdown of rates of different mental disorders according to ethnicity and also gender and highlights groups at higher risk of certain mental health conditions. For example, South Asian women have higher rates of common mental health disorders (CMD) – that include depression and anxiety, than other ethnic groups. Black men have the highest rate of drug use whereas white men have the highest rate of alcohol dependence.

Figure 35 – Age standardised rates of different mental disorder according to ethnicity

	White		Black		South Asian		Other	
	Male	Female	Male	Female	Male	Female	Male	Female
Any CMD	12.0	19.3	12.9	21.0	10.3	34.3	20.2	20.6
PTSD	6.9	10.6	16.3	13.2	11.0	9.1	7.3	5.0
Suicidal thoughts	15.0	20.0	7.1	11.4	6.1	7.7	7.3	12.3
Suicide attempts	4.4	7.1	4.6	7.8	0.6	1.5	4.0	3.3
Self-harm	4.7	5.7	3.3	1.2	2.2	0.9	2.3	6.7
Psychotic disorder	0.2	0.5	3.1			0.6		
Alcohol dependence	9.6	3.7	3.0		1.0		3.5	1.4
Any drug use	12.4	6.8	21.8	5.6	3.5	0.8	9.2	11.5
Drug dependence	4.7	2.2	12.4	4.8	1.5	0.2	2.3	5.0

Source: Dept of Health – No Health Without Mental Health: A cross- Government mental health outcomes strategy for people of all ages Department of Health (2011)

Suicide

Figure 36 below shows suicide rates within a range of countries relevant to Peterborough's population. The suicide rate per 100,000 population is higher in all of the eight EU A8 countries than the UK rate of 7.2/100,000 and is highest in Lithuania (30.7/100,000). Rates are also relatively high in India, but similar to the UK in Pakistan. An annual audit of suicides conducted across both Cambridgeshire and Peterborough has also suggested that suicide rates are higher for people born in Eastern Europe in these localities than would be expected considering the percentage of the total population that these groups comprise as per the 2011 census. Between 2006 and 2015, 16% of suicides in Peterborough were by people born in Eastern Europe.

[34] Oxford Migration Observatory, 'Health of Migrants in the UK: What Do We Know?', 2014 http://www.migrationobservatory.ox.ac.uk/sites/files/migobs/Briefing%20-%20Health%20of%20Migrants%20in%20the%20UK_0.pdf

Figure 36: Suicide rate per 100,000 population 2012 By countries with highest representation in Peterborough

Country	Suicide rate 2012
Lithuania	30.7
Latvia	21.9
Slovenia	21.5
India	20.9
Estonia	18.3
Poland	16.7
Czech Rep	16
Romania	12.7
Portugal	12.5
Slovakia	11.5
Pakistan	7.5
UK	7.2

Source: extracted from World Health Organisation, 2012 Suicide mortality rate (per 100 000 population), by WHO region, by country, 2012, http://apps.who.int/gho/data/node.sdg.3-4-viz-2?lang=en

Higher rates of suicide in both EU A8 countries and among relevant populations that have migrated to England may be symptomatic of health and lifestyle behaviours that are known to be closely related to mental health issues including suicide. For example, evidence suggests a correlation between countries with higher rates of alcohol consumption and higher rates of suicide (Landberg 2008)[35]. Suicide rates are approximately three times higher in men than women in the UK and are also higher in men aged 35-44 as noted in the Cambridgeshire & Peterborough Suicide Prevention Strategy. As many economic migrants are aged between 25 and 39 this could also account for some of the difference in local suicide rates. Despite these possible explanations, the higher rate of suicide by people from Eastern European is of concern.

Dementia

There are increasing indications that the prevalence of dementia in Black African Caribbean and South Asian UK populations is greater than the white UK population (Turner et al, 2012[36]) and that the age of onset is lower for Black African-Caribbean groups than the white UK population. Since these groups are also more likely to experience high blood pressure, it is suggested that the

[35] Landberg, J. (2008) Alcohol and suicide in Eastern Europe, Drug & Alcohol Review, 2008 Jul 27(4) 361-73
[36] Turner, D, Salway, S, Chowbey, P and Mir, G (2012) Mini Case Study Book Real world examples of using evidence to improve health services for minority ethnic people. http://clahrc-sy.nihr.ac.uk/images/health%20inequalities/resources/EEiC_mini_case_study_book.pdf

increased risk of vascular dementia contributes to increased prevalence (Adelman et al, 2009[37], Bhattacharyya, 2012[38]).

Factors affecting dementia awareness and diagnosis in BME groups

Information taken from Central and North West London NHS - David Truswell describing Black, Minority Ethnic and Refugee Communities and Dementia (Reflections from Implementing The National Dementia Strategy in London), suggests several factors that affect the prevalence and diagnosis of dementia in BME communities as follows:

1. Lack of awareness as well as social and cultural factors
2. An expectation of discrimination and/or lack of cultural competence from mental health services
3. Predisposing health factors e.g. South Asian and African Caribbean groups are at increased risk of developing vascular dementia - due to enhanced levels of diabetes and hypertension
4. Professionals' assumptions about lifestyle and care giving cultural norms may inhibit help-giving behaviour
5. Use of appropriately standardised diagnostic tools in assessments needs to be considered

Access to healthcare

The National Institute for Health and Care Excellence publication 'Improving Access to Health and Social Care Services for People Who Do Not Routinely Use Them'[39] states that key barriers to the access of services fall in to two broad categories:

- Structural and service characteristics, such as the structure, organisation and delivery of services and elements of delivery such as location and opening times.
- Population characteristics, including country of origin and cultural/attitudinal and lifestyle characteristics.

As with other themes included within this JSNA, barriers caused by language and cultural differences are considered a primary factor in the observed inequality regarding access to healthcare for some non-UK born populations in comparison to the wider population and resultant issues are likely to be exacerbated by any physical and/or mental health issues suffered by individuals. The East of England Regional Assembly Migrant Health Scoping Report[40] notes that many migrants fail to register with General Practices as a result of misunderstandings about how health services work and because of barriers faced when trying to do so, such as difficulty communicating without translation/interpreting.

GP services

[37] Adelman S (2009b) Prevalence and Recognition of Dementia in Primary care: A Comparison of Older African-Caribbean and White British Residents of Haringey. http://discovery.ucl.ac.uk/19622/1/19622.pdf

[38] Bhattacharyya, S & Benbow, S M (2012) Mental health services for black and minority ethnic elders in the United Kingdom: a systematic review of innovative practice with service provision and policy implications, International Psychogeriatrics

[39] NICE, Improving Access to Health and Social Care Services for People Who Do Not Routinely Use Them (2014), p.2

[40] Collis, A. et al, Migrant Health Scoping Report, East of England Regional Assembly (2009), p. 2

Ethnic mix of General Practices in Peterborough

Ethnicity of patients is recorded by general practices and this information can be analysed to compare ethnic mix between practices and across regions. Ethnicity is broken down into several categories, similar to those given in Census data (see chapter 3). The proportions of practice population registrants assigned to each ethnic category will be useful to commissioners and practice managers as they consider resources, initiatives and interventions that are appropriate for their population.

The general practices with the highest proportions of registered people with Asian Pakistani and Asian Indian ethnicities are shown in the next two figures. As expected, general practices in the more central Peterborough city areas have higher proportional registrations of people from the Asian communities, reflecting the Census data on where these communities reside.

Figure 37 - General Practices in the 'greater Peterborough' area with the greatest proportion of practice population registered as Asian/Pakistani by ethnic category (April 2015)

Practice name	Asian: Pakistani	White: British	Rank
Millfield Medical Centre, Peterborough	21.78	43.05	1
The Grange Medical Centre, Peterborough	17.54	54.83	2
Dogsthorpe Medical Centre, Peterborough	16.84	50.84	3
Thistlemoor Road, Peterborough	16.01	51.87	4
Welland Medical Practice, Peterborough	14.77	52.01	5
Huntly Grove, Peterborough	14.27	58.59	6
Westgate Surgery, Peterborough	13.69	54.66	7
Park Med Centre, Peterborough	11.07	59.78	8
63 Lincoln Road, Peterborough	10.00	65.09	9
Thomas Walker, Peterborough	9.84	64.62	10

Figure 38 - General Practices in the 'greater Peterborough' area with the greatest proportion of practice population registered as Asian/Indian by ethnic category

A different picture emerges for practices with higher proportions of registrations by people in the ethnic category Asian/Chinese. The practice with the greatest proportion of people registered with Chinese ethnicity is at Hampton Health (1.08%), which is located outside the city centre area of Peterborough (data not shown).

The proportion of patients registered as 'white other' with pratices in the Greater Peterborough system ranged from 1.79% (Jenner Health, Whittlesey) to 18.52% (Millfield practice). The general practices with 10% or more people registered as 'white other' are listed in the table below. The 'white other'category includes Eastern European ethnicities but also people from western Europe or the USA, for example.

Figure 39: General Practices in the 'greater Peterborough' area with over 10% of the practice population listed with ethnicity 'white other' (April 2015)

Practice name	% White: Other
Millfield Medical Centre, Peterborough	18.52
Parnwell Medical Centre, Peterborough	17.56
Thistlemoor Road, Peterborough	17.29
Welland Medical Practice, Peterborough	16.57
Dogsthorpe Medical Centre, Peterborough	16.08
Westgate Surgery, Peterborough	15.60
Park Med Centre, Peterborough	14.53
Huntly Grove, Peterborough	13.93
North St, Peterborough	12.65
Minster Practice, Peterborough	12.53
Thomas Walker, Peterborough	12.53
63 Lincoln Road, Peterborough	11.99
Westwood Clinic, Peterborough	11.39
The Grange Medical Centre, Peterborough	11.31
Old Fletton	11.06
Botolph Bridge, Peterborough	10.37

Source: Cambridgeshire & Peterborough Clinical Commissioning Group GP Statistics

Westwood clinic in central Peterborough has the highest proportion of people registered with Black Caribbean or black African ethnicities. However, there seems to be more dispersal of people with Black ethnicities registered to general practices across the Peterborough area, which reflects Census data on residential location of these communities.

Figure 40 - General Practices in the 'greater Peterborough' area with the greatest proportion of practice population registered as Black:African by ethnic category (April 2015)

Practice name	Black: African	White: British	Rank
Westwood Clinic, Peterborough	2.15	66.18	1
Nene Valley Medical Practice	2.15	80.48	2
Hampton Health	2.15	75.42	3
Orton Bushfield Medical Practice	1.91	81.53	4
Bretton Medical Practice	1.89	73.70	5
Parnwell Medical Centre, Peterborough	1.77	66.74	6
Botolph Bridge, Peterborough	1.77	76.52	7
Westgate Surgery, Peterborough	1.57	54.66	8
Welland Medical Practice, Peterborough	1.55	52.01	9
Millfield Medical Centre, Peterborough	1.48	43.05	10

Figure 41 - General Practices in the 'greater Peterborough' area with the greatest proportion of practice population registered as Black:Caribbean by ethnic category (April 2015)

Practice name	Black: Carribean	White: British	Rank
Westwood Clinic, Peterborough	0.98	66.18	1
Bretton Medical Practice	0.91	73.70	2
Parnwell Medical Centre, Peterborough	0.90	66.74	3
Paston	0.80	79.49	4
Hampton Health	0.76	75.42	5
Dogsthorpe Medical Centre, Peterborough	0.73	50.84	6
The Grange Medical Centre, Peterborough	0.73	54.83	7
Welland Medical Practice, Peterborough	0.73	52.01	8
Westgate Surgery, Peterborough	0.71	54.66	9
Park Med Centre, Peterborough	0.70	59.78	10

Changes in GP registrations of non-UK born residents

A measure of recent increases in needs for health services for non-UK born residents is gained from data recording new migrant GP registrations. The figure below shows new migrant GP registrations over a ten year period in Peterborough and across Cambridgeshire to assess trend. This information provides some insight into regions with faster growing migrant populations and the associated need for primary care services.

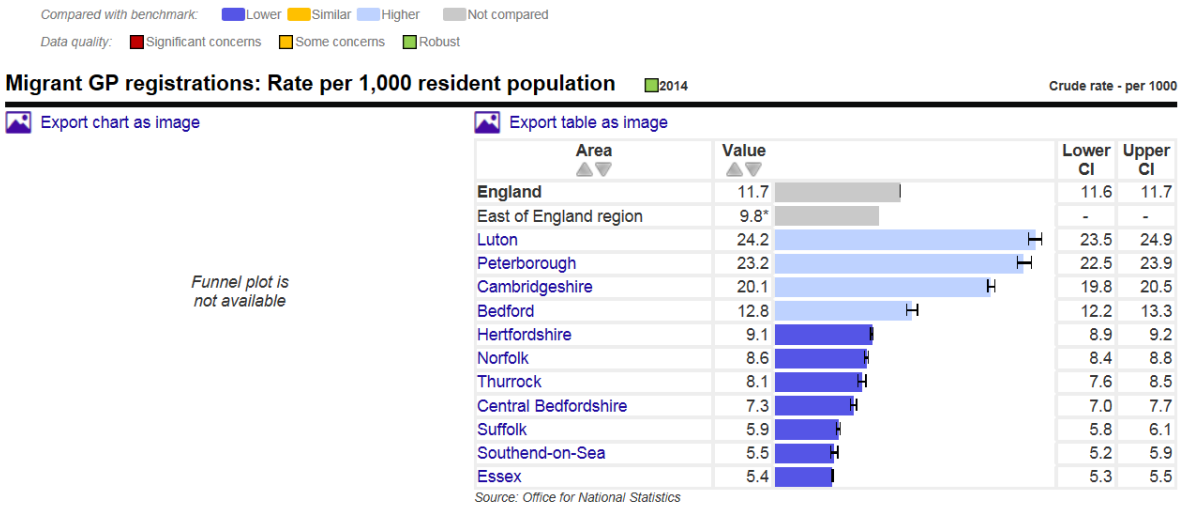
Figure 42: New Migrant GP Registrations, 2003/04 – 2014/15

Area	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
England	460,705	520,899	551,602	581,279	587,993	577,566	604,357	613,124	578,105	587,279	633,738
East of England	41,860	48,621	52,108	54,525	56,342	54,333	54,282	56,795	55,429	55,285	58,885
Peterborough	2,573	3,610	3,586	4,249	4,670	4,730	4,819	4,826	4,789	4,572	4,415
Cambridgeshire	8,270	9,301	9,653	9,711	11,229	10,837	11,222	11,683	11,474	11,889	12,868
Cambridge City	4,557	5,242	5,128	5,163	5,943	6,068	6,379	6,567	6,599	7,266	7,721
East Cambridgeshire	1,586	1,445	1,547	1,548	1,759	1,170	1,123	1,215	1,105	1,113	1,313
Fenland	585	627	1,086	999	1,324	1,291	1,405	1,538	1,464	1,374	1,249
Huntingdonshire	686	931	948	1,038	1,176	1,111	1,197	1,126	1,182	1,114	1,252
South Cambridgeshire	856	1,056	944	963	1,027	1,197	1,118	1,237	1,124	1,022	1,333

Source: Source: Office for National Statistics, Vital Statistics: Population & Health Reference Tables, URL: http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/vitalstatisticspopulationandhealthreferencetables

Data show that annual new migrant GP registrations have increased in Peterborough between 2003/04 and 2010/11 from 2,573 to 4,819. Since then they have shown a small decrease to 4415. When new migrant GP registrations are compared as a rate per 1,000 population across the eastern region, it is clear that Peterborough has the second highest recorded rate and Cambridgeshire third highest rate.

Figure 43: Migrant GP registrations as a rate comparing local authority areas across the Eastern region, 2014



Source: Office for National Statistics

Although the rate of mew migrant GP registrations is lower overall in Cambridgeshire compared to Peterborough, Cambridge City has the highest rate within Cambridgeshire (almost three times the county average) – Figure 44 below.

Figure 44: New migrant GP registrations as a rate per 1,000 population, comparing Peterborough, Cambridgeshire and Cambridgeshire districts, 2014

District	Rate	Lower CI	Upper CI	Statistical Significance
Peterborough	23.2	22.5	23.9	High
Cambridgeshire	20.1	19.8	20.5	High
Cambridge City	60.1	58.8	61.4	High
East Cambridgeshire	15.2	14.3	16.0	High
Fenland	12.8	12.1	13.5	High
Huntingdonshire	7.2	6.8	7.6	Low
South Cambridgeshire	8.7	8.2	9.2	Low
England	11.7	11.6	11.7	-

Source: Office for National Statistics

New migrants who do not register with a GP

To describe the health needs of the non-UK born population, it is important to understand any unmet need in terms of the proportion of new migrants who do not register with a GP and may then either miss out on primary health care or use the health services inappropriately (George et al, 2011).[41]

It is problematic to obtain data to precisely reveal the proportion of new migrants who register with a GP and in most instances, the results of local surveys are used to this effect. A Cambridgeshire and Peterborough Eastern European migrant survey indicated that 93% of the 128 people who answered the question, said they were registered with a GP. However, this survey will not represent migrants

[41] George, A. et al (2011), Impact of migration on the consumption of education and children's services and thehe consumption of health services, social care and social services, National Institute of Economic and Social Research

from other diverse ethnic backgrounds. It also may not represent new migrants as 91.7% of the people who answered the survey had been living in the UK for more than one year. In addition, the survey results were heavily biased towards women migrants, who may be more likely to register with a GP. Research carried out in the South East found that registration rates were higher for females and those who had come with their spouse, children or parents. Furthermore, it was ascertained that young people (those aged under 25 years) and more recent migrants were least likely to register (Green, Owen, & Jones, 2008)[42].

Barriers to accessing primary care include language difficulties, differences in cultural norms and practical issues (Scullion and Morris, 2009, Humphries et al 2015)[43] [44]. Studies have also revealed that migrants who received accessible information were more likely to have registered with a GP (Humphries, 2015)[45]. In addition, migrant groups with the highest health needs are often the ones with the lowest proportion registered with primary care (Stagg et al, 2012)[46].

Comparing GP registrations to new National Insurance number registrations

It would be expected that every person registering for a national insurance number would also register with a GP and that the total number of new GP registrations by migrants will be greater than the total number of new national insurance number registrations, given that some migrants will have no need for a national insurance number – if they are children for example.

When the total number of new migrant GP registrations are comp[ared with the new National Insurance number registrations over a three year period, Peterborough showed a higher proportion of GP registrations compared with National Insurance registrations, as expected. (See fig 45 overleaf).

Figure 45 – Comparison of new migrant GP registrations with National Insurance number registrations, 2012 – 2014 for all Cambridgeshire districts and Peterborough

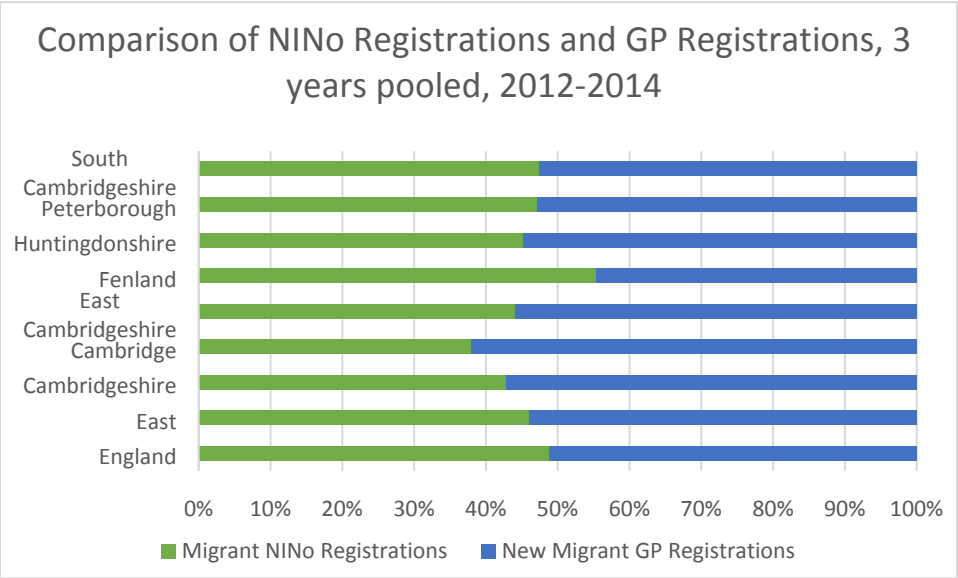
[42] Green, A. & Jones, P. (2008) Migrant Worker and Changing Economic Circumstances: Implications for Regional Labour Markets – The Case of the East Midlands in Recession, Institute for Employment Research, University of Warwick and Sheffield Hallam University

[43] Scullion, L. & Morris, G. (2009) A study of migrant workers in Peterborough, University of Salford

[44] Humphries, L. et al (2015) Migrant Workers Accessing Healthcare in Norfolk, Healthwatch Norfolk (1)

[45] Humphries, L. (2015) Migrant Workers Accessing Healthcare in Norfolk, Healthwatch Norfolk (2)

[46] Stagg, H. et al (2012) Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study, BMJ Open 2012, 2: e001453, doi: 10.1136/bmjopen-2012-001453



Source: Oxford Migration Observatory

Secondary care (hospital services)

With regards to secondary care use, there is evidence that the rate of admission to hospital among international migrants registering with a GP for the first time is only around half the overall national admission rate (with observed indirectly standardised admission ratios of between 56.0 and 57.0 compared to the England value of 100.0 over a three year period)[47]. As well as 'barriers to access', einclouding language and cultural factors, possible reasons for this difference in admission rates include a greater level of overall good health in international migrants than the general population (e.g. people travelling internationally for economic reasons are unlikely to have disabilities or serious illnesses and be relatively young) as well as the possibility that some international migrants might return to their country of origin for hospital treatment.

Irrespective of the reason(s) for this disparity, the data suggest that an increase in migrant population does not necessarily lead to an increase in burden on either primary or secondary healthcare services, although the aforementioned study does include caveats regarding the use of admission rates of economic migrants registered with a GP as an accurate barometer of true levels of demand. For example the registered population would not include migrants arriving at A&E departments without previously registering with a GP and reports of pregnant women who migrated for economic reasons presenting very late in pregnancy without having had a routine medical examination.

This perspective is further supported by the National Institute of Economic and Social Research (NIESR) which estimated that, despite the possibility of higher use of A&E by migrants, the overall annual expenditure on healthcare was £2,003 for British born and £1,602 for migrants in 2011 (George et al, 2011)[48].

[47] Steventon, A. & Bardsley, M., Journal of Health Services Research & Policy, Vol 16, 2, 90-94 (2011)
[48] George, A. et al (2011) Impact of migration on the consumption of education and children's services and the consumption of health services, social care and social services, UK Government

There are anecdotal descriptions of 'unnecessary' attendance at A&E by recent migrants, and this is explored further in Appendix A in relation to the Eastern European population. National research indicates that the picture may be complicated by confusion within GP practices themselves regarding what services they are obligated to deliver and to whom. The 2013 Department of Health paper 'Qualitative Assessment of Visitor and Migrant use of the NHS in England: Observations from the Front Line'[49] notes issues including confusion between primary and secondary providers with regards to the responsibility for treatment of economic migrants with pre-existing conditions such as diabetes resulting in referrals to A&E for inappropriate reasons, and a lack of consistency in approach between GPs.

The eradication of barriers to accessing appropriate healthhcare services for ethnic minority communities continue to be of kinterest to stakeholders across the health economy. An example of good practice In the London borough of Merton was a project between nurses, GPs and community workers, to develop a programme that supported ethnic minority and migrant communities, particularly in relation to their understanding of available healthcare. This was associated with a reduction in A&E attendances within the area of 15.6% between 2007/08 and 2011/12, from 84,537 to 71,374[50]. Although this fall cannot be attributed solely to reductions in A&E attendance among migrant/ethnic minority communities, one third of electoral wards had a majority ethnic minority population so it may be inferred that this targeted work contributed to a reduction in A&E attendance among the overall population.

Among migrants who registered with a GP, the Merton project found that lack of adequate translation and interpreting services can deny migrants access to the same quality of care as received by those who primarily speak English and this creates a risk around incorrect diagnosis and inappropriate care. Lack of informal support networks, mobility of migrant families and cultural differences are also observed as having an effect on both need and access to mental health and maternity services. The findings of the project are summarised in five 'key messages' for developing user friendly services for minority ethnic groups:

1. **Get to know your local communities:** Run workshops/collect survey data and apply findings to the modelling of service provision, tailoring need to meet the needs of minority ethnic communities.
2. **Work with others:** Efforts should be spread proportionally by need across social groups and geographical areas and partnerships should be developed across appropriate sectors to develop adequate support for people of all ages, across all communities.
3. **Build in time to develop trust:** Minority communities may have different beliefs and expectations about health and wellbeing services, including cultural differences developed by healthcare systems in their country of origin, such as experience of different financial models and perceived 'weakness' if admitting they are unwell. It may take time to help people understand the health services that are available to them and it is important to be realistic about expectations when setting up new services.
4. **Spread knowledge:** In Merton, it became apparent that people were using A&E services because they did not know what else was available. 51% of surveyed people were not aware of emergency out of hours services and the project emphasised the need to explain primary care, pharmacy and out-of-hours services at every contact and via translated posters and leaflets.

[49] Creative Research for the Department of Health, 'Qualitative Assessment of Visitor and Migrant use of the NHS in England: Observations from the Front Line (2013), p. 152

[50] Ford, A. et al, Cutting A&E Use and Health Inequalities, Nursing Times, Jun19-Jun 25, 109, 24 (2013)

5. **Look for 'quick wins':** Demonstrating how projects are making a difference to attitudes and behaviours is key to keep stakeholders motivated to take part, keep funders interested and build momentum.

Examples of good practice in primary care

There are some examples of good practice to encourage GP engagement with non-UK born residents:

- GP services having once a week drop in sessions with interpreters available – cost saving and effective. Improved access to community-based GPs and delivery of more appropriate care may lessen the impact on acute services (Hargreaves et al, 2006)[51]
- Marginalised and vulnerable adults service – Ipswich – provides initial GP appointments at double standard time as they appreciate language will be an issue – this is thought to prevent issues later in care

6. Recommendations

A number of recommendations are made to build on the findings of the Peterborough Diverse Ethnic Communities JSNA.

- The Cambridgeshire and Peterborough Clinical Commissioning Group, NHS England East, and local NHS providers should use the information about diverse ethnic communities in this JSNA when planning and delivering services. This will support the NHS duties to consider the needs of equalities groups and to reduce health inequalities.
- Healthcare Providers should review the quality and completeness of their recording of ethnicity in order to ensure that information is available on service use in relation to needs.
- Peterborough City Council should also use the information from the JSNA where relevant when planning and delivering services.
- Further work to engage with a range of minority ethnic communities in Peterborough should take place, similar to the engagement work with Eastern European communities for Appendix A of this report, and this should report back to the HWB Board.

APPENDIX A

Pilot work: Eastern European migrant population

7.1 Introduction & Overview

[51] Hargreaves, S. et al (2006) Impact on and use of health services by international migrants: questionnaire survey of inner city London A&E attenders

In recent years, there has been an increasing awareness of migrant workers coming to Peterborough, particularly since the enlargement of the EU in 2004 by the Treaty of Accession to the European Union to include an additional ten countries, eight of which are in Eastern Europe. These Eastern European countries - Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia are often referred to as the 'A8' countries and this term is used throughout the JSNA.

As part of the work on the Diverse Ethnic Communities JSNA - community and stakeholder surveys and a stakeholder event were held to further explore the views and needs of non-UK born residents from A8 countries on factors affecting their health and wellbeing. This has also been supplemented by some additional data analysis. This additional work has led to specific recommendations in relation to the health and wellbeing of A8 communities

It is intended to carry out similar community and stakeholder surveys/events events for other ethnic communities in Peterborough, in order to gain a better understanding of their views and health and wellbeing need. These will be brough to the Health and Wellbeing Board as additional appendices to this JSNA, with further tailored recommendations.

Health and health services

Key messages

- A higher rate of attendance at A&E at weekends by people of Eastern European origin than the general population has been described in Peterborough, although there are uncertainties in the data. The community survey results indicate a need to increase understanding of UK healthcare services, and explore mechanisms to adjust the GP offer for Eastern European migrants in some way.
- Anecdotal evidence highlights cultural differences in health beliefs of Eastern Europeans: There seems to be greater expectation for the medical and pharmaceutical management of minor health issues. There are concerns that it may be difficult to obtain referrals from GPs to a relevant specialist. There seems to be some stigma attached to mental health problems.
- Evidence suggests rates of smoking and excessive alcohol consumption are higher among some Eastern European communities, although rates of alcohol use amongst the individual respondents to the community survey were low. A8 migrants are utilising alcohol treatment services and smoking cessation services, but a lack of trust in health services may be a barrier for engagement as well as some perception that alcohol consumption is a 'way of life' and not a risk to health. Street drinking in the Eastern European population as part of social gatherings may create community tensions.
- Dental health is also an issue – some people from A8 countries present with high levels of untreated decay when they seek dental treatment.

Use of secondary care

Anecdotal evidence suggests that recent migrants – particularly Eastern European migrants, often use secondary care accident and Emergency services at higher rates than the non-migrant population or instead of accessing primary care services.

A project at Peterborough City Hospital placed a GP at the front entrance to the Emergency Department on Saturdays and Sundays between 09:00 – 21:00 to assess the needs of people using the service. This project recorded the ethnic background of people accessing the Emergency Dept. over a six month time period from November 2015 to April 2016.

The data was analysed in terms of the number and proportion of people with Eastern European (A8) backgrounds accessing the Emergency Department compared to all other ethnicities. Over the six month time period analysed, 196 out of a total of 1427, people (14%) who attended the A&E GP service at the weekend were of Eastern European (A8 countries) ethnic origin. This proportion is higher than that given for Eastern Europeans resident in the Peterborough area as provided by census data , although the census data is based on 2011 information. The figure is closer to the 12% of school children recorded as speaking an Eastern European language at home. The analysis therefore indicates there may be higher rate of attendance at A&E at weekends by people of Eastern European (A8) origin than the general population, although there are uncertainties in the data.

Use of primary care – stakeholder feedback

Anecdotal evidence from stakeholders included:

- Community: Health is very important for most of the A8 migrants, so they do register with GP as soon as they arrive in UK. The main concern around primary care is that the GP acts as a gatekeeper and it is very difficult to obtain referrals to a relevant specialist even with serious issues – there are difficulties in explaining the problems to the GP. Also there is an expectation to have blood tests if they have any concerns, but there is a feeling by A8 migrants that this it is not practiced in NHS system.
- Health professional: There are some different health beliefs are different in this population. There may be greater emphasis on use of prescriptions and antibiotics for minor illness. There seems to be a greater expectation for fast access to medical professionals by mothers with young children.

Community Survey

- 93.0% of respondents said they were registered with a GP practice, compared to only 60.6% registered with a local dental practice. 81.1% of people said they had visited a local hospital since arriving in England.
- Although 85.7% of respondents stated that their level of spoken English at least allowed them to participate in simple conversations and 87.1% said their level of written English allowed them to at least understand simple instructions, only 72.8% of respondents said that their understanding of UK healthcare services was 'reasonable' or 'good'. Respondents were asked to rate GP services on a scale of 1-5 (1 = very bad, 5 = very good) and for all categories, the average score provided was at least 3.1; when the same questions were asked about local hospitals, average scores were higher, ranging between 3.9 and 3.3. Respondents scored 'patient communication and respect' 3.1 for GPs and 3.9 for hospitals, suggesting a degree of variation with regards to this measure between GPs and hospitals. For maternity services, average scores were higher than for GPs and hospitals, ranging from 4.2 for accessibility and patient communication and respect to 3.8 for time effectiveness.

- 48.4% of survey respondents said they had not made any appointments for screening or immunisation with their local doctor/GP service (not all may have been due to have a screening test or immunisations) and 27.8% of applicable respondents (people aged 40-74) have had an NHS health check compared with 34.7% for the general Peterborough population.

Alcohol consumption

The World Health Organisation (WHO) estimates that in 2012, about 3.3 million deaths, or 5.9% of all global deaths, were attributable to alcohol consumption. In 2012 139 million DALYs (disability-adjusted life years), or 5.1% of the global burden of disease and injury, were attributable to alcohol consumption. There is also wide geographical variation in the proportion of alcohol-attributable deaths and DALYs, with the highest alcohol-attributable fractions reported in the WHO European Region. (http://www.who.int/mediacentre/factsheets/fs349/en/)

Figure 46: Comparisons of alcohol consumption between the UK and some Eastern European countries

Indicator	UK		Lithuania		Latvia		Poland	
	M	F	M	F	M	F	M	F
Total alcohol per capita (15+), drinkers only(in litres of pure alcohol)	18.9	8.5	33.3	13.5	26.5	10.1	31.5	14.0

Source: WHO country profiles, 2014: Latvia page 221; Lithuania p222; Poland p229; Romania p232; UK p246. http://www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_2.pdf?ua=1

It is clear from the table above that alcohol intake per capita is higher in Lithuania, Latvia and Poland than in the UK. There are potential knock-on consequences for health such as a higher risks of liver cirrhosis and road accidents. This data has potential implications for the health needs of the Eastern European migrant population of Peterborough which include people from Lithuania, Poland and Latvia.

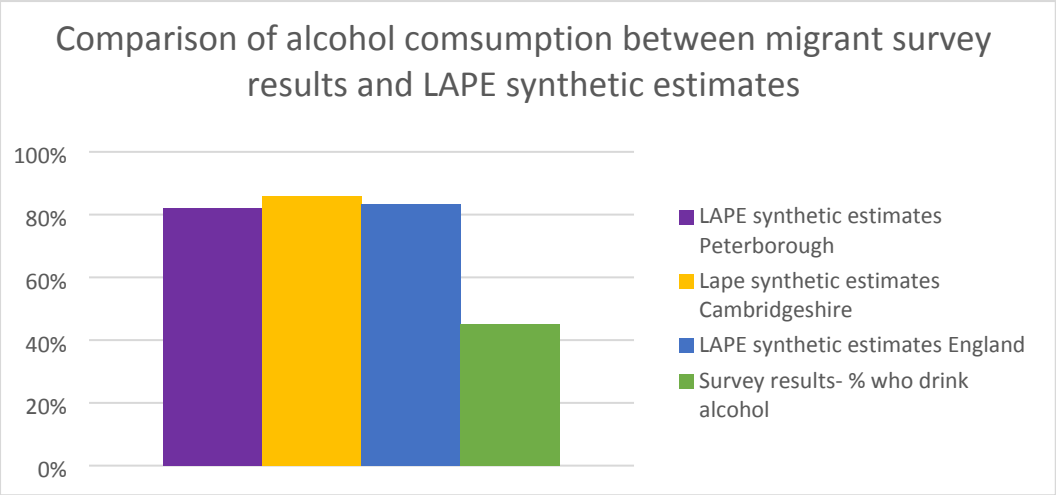
Community Survey

The Community Survey for migrants from A8 countries included the question :
'Do you drink alcohol? If so how often?'

Of the 126 people who answered this question, 54.8% declared that they do not drink alcohol and only 8.7% responding that they drink 3-5 times per week. The survey results show a lower percentage of people in the Eastern European migrant community drink alcohol than is estimated for the general population in Peterborough, Cambridgeshire and England (Figure 47 below).

This result contrasts with WHO data presented above and may indicate a more complicated picture of alcohol consumption in this population. It is important to note that 84% of respondents to the community survey were female, so the survey does not provide a clear picture of alcohol use among Eastern European males.

Figure 47 – Comparison of estimates of the proportion of people who drink in the general population of Peterborough, Cambridgeshire and England with the proportion who drink alcohol as reported by the migrant survey



Source: Mid-2009 synthetic estimates of prevalence taken from the Local Alcohol Profiles for England 2014 and applied to mid-2014 ONS population estimates

Fieldwork by voluntary sector organisation 'DrinkSense' in Peterborough in 2012/13 identified a number of key socio-cultural factors influencing drinking behaviour among young adults from Eastern European communities. The outdoor alcohol consumption perceived as 'street drinking' and usually associated by the British public with anti-social behaviour (ASB) is a common form of socialising unconnected with problematic street drinking in certain European countries, such as: Lithuania, Latvia, Portugal, Poland and Slovakia. These cultural differences lay at the foundation of perception of outdoor alcohol consumption, as this form of socialising is traditionally uncommon for the majority of the British public. As the WHO data also indicates, alcohol may play a significant role in these communities, especially in the consolidation of friendships during sessions of heavy drinking. This may be especially significant for a relatively young diaspora in the UK.

Use of health services for alcohol dependence

Until April 2016, DrinkSense provided an NHS funded community treatment service for people with alcohol problems, with routes to treatment including self-referral and referral from primary care (this has since been replaced by a new contract). Statistics from the DrinkSense alcohol treatment service 2014/15 showed that of 652 clients engaged in the service, 38 people (6%) were Eastern European. This proportion is similar to the proportion of the overall population referenced in the demography section of this paper but it should be acknowledged that individuals in contact with DrinkSense may have particularly extensive needs in relation to language and lack of understanding of UK health services that requires investment in engagement and liaison with relevant communities.

The hospital alcohol liaison service (HALP) places specialist alcohol workers in Peterborough City Hospital who engage patients admitted whose presenting problems may be alcohol related. The objective of this project is to reduce alcohol-related hospital admissions through early intervention. In 2015/16, 10.3% (85/823) of people seen by the HALP service in Peterborough City Hospital were from Eastern Europe. HALP data over the past five years has consistently shown around 10% of patients are European economic migrants This is a higher percentage than those self-referring into

community alcohol treatment services and may indicate that people from these communities are less likely to seek help from preventive services, before alcohol problems result in hospital attendance.

Smoking and tobacco

Fig 48 below shows that For European countries where data were collated, overall smoking prevalence was highest overall in Greece (31.8%), Bulgaria (29.2%) and Latvia (27.9%) and lowest in Slovenia (18.7%), Belgium (18.9%) and Malta (19.2%). In all countries, smoking prevalence was higher in males than in females and the gender difference with regards to consumption is highest in Latvia, where 46.0% of males consumed tobacco compared to only 13.0% of females. Unfortunately comparable statistics for the UK were not collected.

Figure 48: Smoking Prevalence, European Union Member States 2013-15* (Red = EU A8 Accession Countries)

Country	Total (%)	Male (%)	Female (%)	Gender Difference (% Points)
Slovenia	18.7	22.1	15.5	6.6
Belgium	18.9	21.1	17.0	4.1
Malta	19.2	23.8	15.1	8.7
Slovakia	19.3	26.9	12.3	14.6
Romania	20.5	32.7	9.1	23.6
Germany	22.8	25.5	20.3	5.2
Austria	22.9	26.8	19.3	7.5
Poland	23.8	30.9	17.9	13.0
Czech Republic	24.3	29.6	19.4	10.2
Spain	25.2	29.5	21.0	8.5
Estonia	25.9	39.5	15.1	24.4
Cyprus	25.9	37.9	14.3	23.6
Hungary	26.1	31.4	21.5	9.9
Latvia	27.9	46.0	13.0	33.0
Bulgaria	29.2	40.4	18.9	21.5
Greece	31.8	37.8	26.1	11.7

Source: Eurostat Tobacco Consumption Statistics, http://ec.europa.eu/eurostat/statistics-explained/index.php/Tobacco_consumption_statistics

Figure 49 shows smoking prevalence in Cambridgeshire and Peterborough in 2014. The national smoking prevalence is recorded as 18% but this may not be directly comparable with the European figures.

Figure 49: Smoking Prevalence, Public Health Outcomes Framework, 2014

Area	Smoking Prevalence
Peterborough	18.6
Cambridgeshire	15.5
Cambridge City	17.6
East Cambridgeshire	14.9
Fenland	21.2
Huntingdonshire	14.4
South Cambridgeshire	11.7
England	18.0

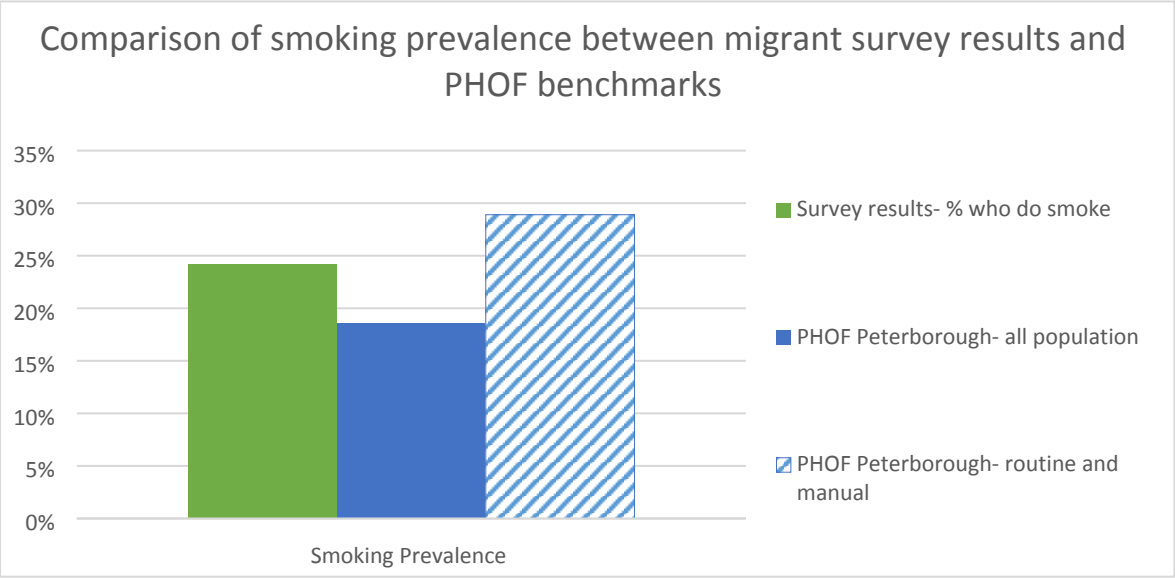
Source: Public Health Outcomes Framework, Indicator 2.14

Compared with benchmark: Better Similar Worse

Community Survey

The migrant survey for Cambridgeshire and Peterborough showed that 24.3 % of the respondents who answered the question – 'Do you smoke cigarettes?', said they smoked. This is higher than local overall smoking prevalence but similar to smoking prevalence in the local 'routine and manual' occupation groups for Cambridgeshire but lower than the 'routine and manual' group for Peterborough (Figure 50 below). Because 84% of the survey respondents were females, who usually have lower smoking rates in Eastern European countries, it is likely that actual smoking prevalence among Eastern Europeans in Peterborough is higher than 24.3%.

Figure 50: Comparison of smoking rates between the migrant survey results and PHOF benchmarks for Peterborough and Cambridgeshire



Source: Cambridgeshire & Peterborough Migrant Health Survey 2015/16 & Public Health Outcomes Framework

Residents of 'white other' ethnicity using the smoking cessation service in Peterborough

Peterborough smoking cessation service records information on the number of people classified as 'white other' who have used the service and 'set a quit date' or who have 'successfully quit'.

For the first three quarters of 2015/16, close to 20% of all 'quitters' (99 out of 488) were classified as 'white other' (any white ethnic group that isn't white Irish or white British), with similar numbers of men and women represented. This suggests that Eastern European migrants are engaging with the service, although caution should be applied as more detailed information on country of birth is not available.

It has also been reported by stakeholders that a high proportion of people attending the smoking cessation service from some GP practices are from migrant Eastern European backgrounds.

Oral Health

Across Europe, oral disease (disease involving the mouth and/or teeth) constitutes a major public health burden and significant oral health inequalities exist both within and between individual member states in terms of severity and prevalence. The burden is attributable principally to dental caries, periodontal disease and oral cancer.[52] Oral disease not only impacts on the individual by causing pain and discomfort as well as a broader impact on quality of life, but also increases need for relevant health services. [53] Despite a global decline in dental caries, the disease still remains a problem for many groups in Eastern Europe and for those from socioeconomically deprived groups in all European Union member states. Numbers of decayed, missing and filled teeth due to caries are higher for Central and Eastern Europe than the European average and significant proportions of children are in need of care.

Data from surveys carried out in Poland show that only 64% of school children brushed their teeth at least twice a day and 70% consumed sweets 'every day or several times a week'.[54] Several studies conducted in Eastern Europe have shown that school health education programmes can be instrumental in development of healthy lifestyles in oral health as well as general health.

It is estimated that over 50% of European populations may suffer from some form of periodontal disease and over 10% have severe periodontal disease; additionally, trends in oral cancer are now showing an increasing incidence in women and young adults.[55] Access to dental services in Eastern Europe is variable and the quality of dental services is inconsistent. Ensuring access to oral health care services remains a major health problem among vulnerable and low income groups, including migrant populations, for whom aforementioned barriers regarding language and culture as well as prohibitive cost may discourage attendance.

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[52] Patel R. September (2012). The state of oral health in Europe. Report commissioned by the Platform for Better Oral Health in Europe.

[53] Peterson P. (2003). World Health Organisation, Changing oral health profiles of children in Central and Eastern Europe, Challenges for 21st Century. URL: http;//www.who.int/oral_health/media/en/orh_eastern_europe.pdf p.2

[54] Peterson P. (2003). World Health Organisation, Changing oral health profiles of children in Central and Eastern Europe, Challenges for 21st Century. URL: http;//www.who.int/oral_health/media/en/orh_eastern_europe.pdf p.3

[55] Boyle P, Levin B. (2008). World cancer report. Lyon. International Agency for Research on Cancer

IARC International Agency for Research on Cancer GLOBOCAN (2008) (c) WHO

Community and Stakeholder Surveys

The Community Survey results show that 60.6% of respondents had registered with a dentist. A survey of dental staff working in Peterborough and Wisbech Dental Access Centres (DAC) outlines the following broad trends with regards to oral health of the local Eastern European migrant population:

- People tend to present with high levels of untreated decay and are often in high levels of pain and distress when they seek dental treatment.
- Levels of previous dental care often appear to be relatively poor and treatment issues are exacerbated by a lack of education and understanding regarding personal oral health
- Many patients report that they cannot find NHS dentists willing to accept them for treatment and that it is not possible for them to attend scheduled appointment times due to fear or loss of income or losing their jobs altogether. Anecdotal evidence suggests that appointments may be accepted but then not attended, primarily for the aforementioned reasons, which increases the 'Did Not Attend' rate of local Dental Practices.
- There is potential for the NHS payment system resulting in high needs patients being refused care as these patients are not seen to be 'financially viable'. Further research would be required to assess this issue, and the suggestion that dental appointments within standard working hours are difficult to attend for migrant workers.

7.2 Children & Education

Key Messages

- 12% (4,126 pupils) of all school pupils speak an Eastern European A8 language at home in Peterborough. This proportion is higher in primary schools (13.5%) compared with 9.9% in secondary schools.
- Three of the five primary schools with the highest percentage of pupils speaking an EU A8 language are located in the East electoral ward, with one school in Central and one in Bretton North.
- The most commonly spoken EU A8 language among pupils of school age is Polish (42.2%), followed by Lithuanian (27.7%) and Latvian (10.6%).
- Although academic attainment as measured by outcomes in the early years foundation stage profile, key stage 2 and at GCSE level has improved between 2013 and 2015 in Peterborough for pupils who primarily speak a Central or Eastern European language at home, attainment remains below that of pupils who primarily speak English.
- Communication with parents can be problematic due to poor English skills, and to parents not being clear who to speak to about issues or difficulties. Parents may work 'unsocial' hours and may not available to attend meetings at the school. Pupils may arrive to join a school throughout the school year, which can make it more difficult to address language needs.

Introduction

This section explores the demographics of schools across the region in terms of ethnicity of pupils and language spoken at home. Educational achievement is reviewed in terms of language spoken at home at key points in the educational system. The issues of pupils from Eastern European backgrounds are highlighted where information is available.

Demographics

The ethnic category 'any other white' includes Eastern European migrants. In Peterborough, 16% of school pupils are 'white other' compared with 10.6% of people of all ages recorded in the 2011 Census. This suggests that either the population of 'white other' has increased in Peterborough since 2011 or there are proportionately more school aged 'white other' people than there are in the general population.

Figure 51: Comparisons of the proportion of pupils classified as 'white other' across Cambridgeshire and Peterborough 2015 School Census & 2011 Census

Area	Any Other White (School Census 2015)	Any Other White (Census 2011)
Peterborough	16.0%	10.6%
Cambridgeshire	8.3%	7.1%
Cambridge City	14.9%	15.0%
East Cambridgeshire	6.9%	5.6%
Fenland	10.4%	5.9%
Huntingdonshire	5.7%	4.5%
South Cambridgeshire	6.7%	5.0%
Cambridgeshire & Peterborough	10.6%	7.9%

Source: Cambridgeshire County Council & Peterborough City Council Education Data, 2015 School Census & Census 2011

Eastern European (A8) pupils in Peterborough

The school census data records information on the primary language spoken at home by pupils. This information has been analysed to identify the proportion of pupils in Peterborough and Cambridgeshire who speak an European Union A8 language at home – Czech, Estonian, Hungarian, Latvian, Lithuanian, Polish, Slovak or Slovenian.

Overall, 12% (4,126 pupils) of all school pupils speak an Eastern European A8 language at home in Peterborough. This proportion is three times higher than for the whole of Cambridgeshire. This proportion should be compared with the school Census information above that records 16% of Peterborough pupils as 'white other' in ethnicity, suggesting that the majority of the 'white other' pupils are from Eastern European countries. The proportion of pupils who sperak an Eastern European language at home are higher among primary school age pupils in comparison to secondary school age pupils, (13.5% in primary schools compared to 9.9% in secondary schools and 14.1% in 'other' schools). This suggests that the proportion within secondary schools will increase in coming years.

Figure 52: The proportion of school age pupils across Peterborough, Cambridgeshire and Cambridge districts who speak an Eastern European A8 language at home

Area	Number and Percentage of Pupils Speaking EU A8 Primary Language							
	Primary		Secondary		Other*		All Schools	
	Number	%	Number	%	Number	%	Number	%
Peterborough	2,422	13.5%	1,415	9.9%	289	14.1%	4,126	12.0%
Cambridgeshire	2,100	4.4%	879	2.8%	17	1.8%	2,996	3.8%
Cambridgeshire & Peterborough	4522	6.9%	2,294	5.1%	306	10.3%	7,122	6.3%

Source: Cambridgeshire County Council & Peterborough City Council Education Data, 2015 School Census & Census 2011

*'Other' schools includes infant schools, junior schools, pupil referral services and special schools.

Primary school pupils in Peterborough who speak an Eastern European language

Analysis of data for each primary school in Peterborough showed a range of between 0% and 36.4% of pupils who speak an Eastern European language at home. Three of the five primary schools with the highest percentage of pupils speaking an EU A8 language (all over 30% of pupils) are located in the East electoral ward, with one school in Central and one in Bretton North.

Eastern European language spoken at home by school aged pupils

The figures below show the proportion of primary school children who speak each Eastern European A8 language. The most widely spoken Eastern European language spoken by primary pupils is Polish, followed by Lithuanian, Slovakian, Latvian and Czech

Figure 53: The language spoken at home by pupils who speak an Eastern European A8 language – Peterborough Primary Schools, School Census 2015

Percentages	Czech	Estonian	Hungarian	Latvian	Lithuanian	Polish	Slovakian	Slovenian	EU A8 Total	All Other	Total
Peterborough (In Comparison to All)	1.0%	0.0%	0.3%	1.4%	3.7%	5.7%	1.4%	0.0%	13.5%	86.5%	100.0%
Peterborough (In Comparison to other EU A8 Only)	7.1%	0.1%	1.9%	10.3%	27.6%	42.2%	10.5%	0.2%	100.0%	-	-

Source: Cambridgeshire County Council & Peterborough City Council Education Data, 2015 School Census

Educational attainment of pupils assessed in relation to the primary language spoken at home

- Educational attainment is covered in the main body of this JSNA which gives details of educational achievement of pupils who do not speak English at home from early years education through to GCSE performance. It shows that, in general, educational attainment at Foundation stage, Key stage 2 and GCSE is lower for pupils who speak a language other than English at home, and this is most marked for pupils who speak an Eastern European language. However the improvement in attainment between 2013 and 2015 has also been fastest for pupils speaking an Eastern European language at home.

Stakeholder Suvery - Eastern European (A8) pupils in secondary education in Peterborough

The specific needs of Eastern European pupils identified by a stakeholder survey of secondary schools in Peterborough include the following:

- Isolation – this concern reduces as the numbers of Eastern European pupils increase in a school. Immersion of new arrival students into the mainstream school helps to limit isolation
- English language acquisition – this occurs faster when pupils are integrated with other students
- Language barriers for Eastern European parents – communication with parents can be difficult. There is anecdotal evidence that Eastern European parents may not attend parent's evenings as much as the general population and this may be due to both language barriers and work commitments, with parents working 'unsocial' shifts and therefore not being available to attend parent's evenings.
- There may be difficulties engaging with Eastern European parents to discuss students with problems in school due to behaviour or attendance. Parents may not know where to go for help if their child is having difficulties or what services are available and how to access them.
- Some families do not acknowledge mental health as a problem and students may be embarrassed, ashamed or afraid to speak about mental health issues
- Domestic violence at home is mentioned anecdotally as an issue that arises for some pupils
- Attendance may sometimes be affected for Eastern European pupils due to visits to home countries
- Eastern European pupils may sometimes have low aspirations
- Cultural differences can create issues

There is evidence that the arrival of children of economic migrants at a time other than at the scheduled start of the school year (e.g. due to arrival in the country mid-term) creates difficulty for schools in meeting relevant language needs and can also lead to difficulties in maintaining records of a child's education progress if the economic necessity leads to the child moving from school to school throughout their education[56].

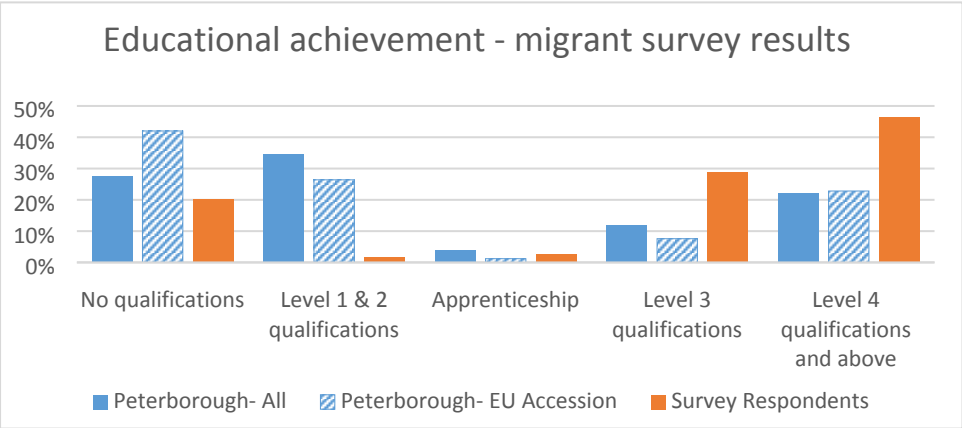
Community Survey

Educational attainment level in the migrant population – results from the migrant survey

The Community survey asked a question to determine the educational attainment level of respondents. The results are presented in the figure below and are compared with the general population and also people from EU accession countries living in Peterborough and Cambridgeshire (as recorded in the 2011 Census).

[56] George, A. et al, 'Impact of Migration on the Consumption of Education and Children's Services and the Consumption of Health Services, Social Care and Social Services, 2011 P.23

Figure 54 – Educational attainment level of migrants responding to the migrant survey compared with the general population and people from EU accession countries in Peterborough and Cambridgeshire



Source: Peterborough City Council/Cambridgeshire County Council Survey Data

This chart shows that whereas non-Uk residents born in EU accession countries were more likely than all Peterborough residents to have no qualifications according to the 2011 Census, respondents to the Community Survey are more likely to have a higher level of qualifications than average. Therefore the survey may not be fully representative.

7.3 Employment

Key Findings

- Peterborough has a higher proportion of Non-UK born residents who are employed compared with both England and the East of England (63.3%, compared with 56.7% and 61.2%, respectively).
- Evidence suggests that A8 migrants may often work in low-skilled, seasonal jobs that are low-paid and may be subject to zero-hours contract. The migrants are employed in these type of jobs because of poor English language skills, yet many migrant workers work below their skill level. Seasonal and shift work makes it difficult for migrant workers to make contact with services or seek help when needed. It also has an impact on social life and leads to isolation.
- Migrants can face financial challenges when work 'dries up' or if they cannot work due to sickness. Eviction from housing is often a consequence of financial difficulties and loss of work.
- Employment issues can arise due to low levels of understanding or lack of appropriate information about work entitlements, employment rights, holiday or sickness pay, access to benefits such as tax credits, or how the tax system works.
- The migrant survey showed that 21% of respondents said they have concerns about their safety at work on at least some days.

- Some community stakeholder feedback indicated that modern slavery and human trafficking is an issue, although being addressed by police and local authority.
- Language is a barrier to employment – the youth coming to UK have good knowledge of English, but the older migrants, especially those who work in factories/fields have less ability and struggle to find time to study. Certified ESOL provision can be expensive.

Legal rights of A8 nationals in the UK

A8 nationals currently have the same rights as any other workers from the EU and European Economic Area (EEA). These rights include:

- the general right to 'free movement' within the EU/EEA.
- the right to live in the UK for up to three months and longer if the person is able to support themselves financially
- the right to live in the UK as a student
- the right to seek work
- the right to work
- the right to enter self-employment or set up a business

Other rights depend on whether the EEA national is classified as a 'worker' as follows:

- currently employed
- temporarily unable to work because of sickness or an accident
- were working for at least one year and are now registered as a jobseeker
- were in work but are now in vocational training
- unable to work due to pregnancy or childbirth as long as there is an intention to return to work within a 'reasonable period', usually 52 weeks

EEA migrants cannot claim income-based Jobseeker's Allowance until they have been in the country for three months. Jobseeker's Allowance can only be claimed for a total of 91 days. All EEA nationals who are receiving Jobseekers Allowance are not able to access Housing Benefit. An EEA national who has lost their job and has worked for less than one year can be classified as 'a worker' for six months after losing their job, and claim Jobseeker's Allowance. An EEA national who has worked in the UK for more than a year before becoming involuntarily unemployed may be able to claim income-based jobseeker's allowance for longer than six months if they can provide 'compelling' evidence that they have a genuine chance of finding work.

Employment rates

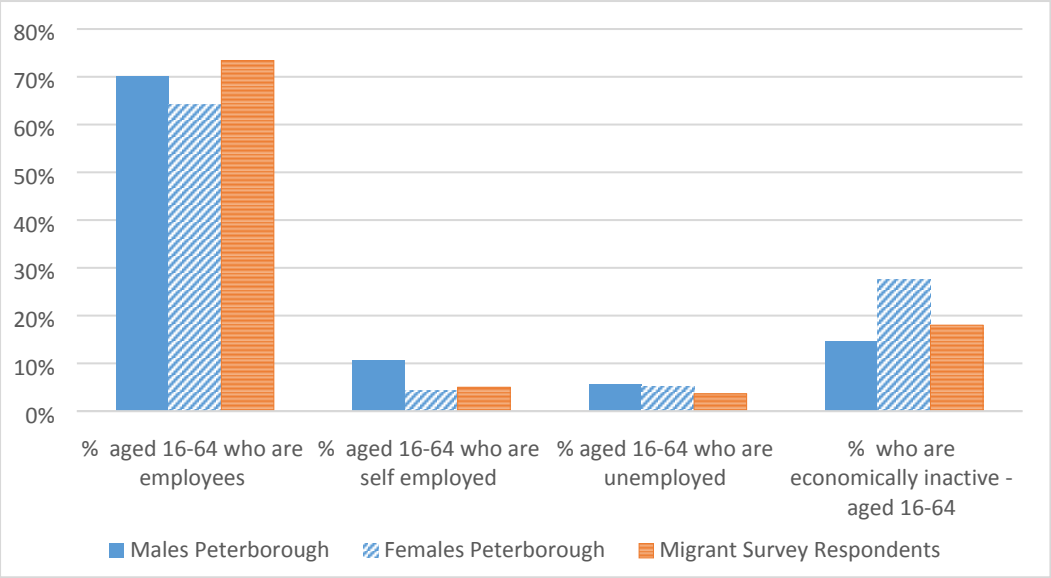
Data shown in Section 2 of this JSNA showed that a higher proportion of Peterborough's non-UK born residents are employed compared with both England and the East of England (63.3%, compared with 56.7% and 61.2%, respectively).

Community Survey Results – employment status

The Community survey included questions around employment status and the results are shown in the figure below, which compares the migrant survey result with the general population of Peterborough.

139 people answered the survey question about employment. The summary survey results are presented as an appendix at the end of this document.

Figure 55: Results of the migrant survey in relation to questions about employment status, comparing survey results with the general population of Peterborough



Source: Cambridgeshire & Peterborough Migrant Healthy Survey 2015/16

The Community survey results show a slightly higher proportion of migrants in employment as employees than the general population for both sexes. Unemployment is lower than the general population of Peterborough. The proportion of migrants describing themselves as 'economically inactive' is lower than Peterborough females and higher than males. The migrant survey respondents were predominantly female and this may explain the finding shown.

This data indicates that Eastern European migrants are predominantly settling in Peterborough for employment and are economically active.

Safety at work

An area of concern that arose from the migrant survey results was that of safety in the workplace. 21% of 105 respondents who answered a question about how safe they feel in their working environment said they have concerns about their safety on at least some days.

Issues identified in the Eastern European community in Fenland and Peterborough

Information on issues that arise in Eastern European migrants to Fenland was obtained from Cambridgeshire Human rights and Equality Support Services (CHESS) - an organisation that provides advice to migrants within the Fenland area on housing and Employment. In addition, the findings of a Peterborough migrant study in 2009 are included where consistent issues were identified[57].

- Often migrants work in low-skilled, low-paid jobs and may be subject to zero-hours contract. When the work is finished, the worker is left with no job and no money until the next job arises.
- There is a lack of understanding or lack of appropriate information (in an accessible form – translated into a range of Eastern European languages) about work entitlements, holiday or sickness pay.
- There is a lack of appropriate information on how to access benefits such as tax credits, child tax credits or how the tax system works – how to make tax payments, what the tax codes mean. Some people end up in financial difficulties as a result.
- There is a lack of information about employment rights including issues around discrimination, injury at work, disciplinary actions or dismissal
- Financial difficulties occur due to sickness or zero hours contracts. Eviction from housing is often a consequence of financial difficulties and loss of work.
- Shift work makes it difficult for migrant workers to make contact with services or seek help when needed.

In 2009, of the Eastern European migrants to Peterborough who were involved in the study, 69% were currently working within the Peterborough urban area. The others worked in surrounding counties or further afield - Lincolnshire, Cambridgeshire, Northamptonshire; Bedfordshire and Leicestershire. The majority of respondents worked in elementary occupations (77%). Around 70% of people had experienced a decrease in occupational level from their last job in their home country.

Stakeholder feedback about employment issues

Anecdotal information from a community stakeholder about employment for new migrants indicated that :

Newcomers usually start agency work, and mainly work in the fields. Most who come to work in seasonal employment over the summer, experience the worst working conditions. The migrants are employed in these type of jobs because of poor English language skills. Most agencies employ on zero hour contracts, which are temporary and not stable positions. This is convenient to the agencies as they can call any person to work when it suits them. This can have an impact on social life and can lead to isolation. People may be scared to take days off because of illness, as they fear that the agency will terminate their contract and they will lose their job.

Modern slavery and human trafficking is an issue, although this is 'in hand' by police and local authorities.

Language is a barrier to employment – youth coming to the UK have a good knowledge of English language, but the older generation, especially those who work in factories or in fields have less

[57] Ethnic & Racial Studies (2011), Journal Volume 34:12, December 2011

ability and time to learn English. The working hours may restrict their time to be able to study. ESOL courses can be expensive for migrants.

Information for Peterborough Eastern Europeans is obtained through social media, like Facebook. There is a Lithuanian magazine 'Svyturys', which is issued quarterly.

Anecdotal evidence from a health professional highlighted issues relating to sickness and work. There may be a requirement for a GP certificate in order to 'sign off' someone from work due to sickness. Without this, the migrant worker may not receive pay. In addition, long hours of physical work experienced by some migrants has lead to muscular-skeletal problems. Stress and problems achieving a good work/life balance have also been noted as potential issues related to long working hours in this population.

7.4 Housing

Key Findings

- The majority of respondents to the Community Survey live in rented accommodation, with 39% living in shared rented housing. This compares with 54% of the general population in Peterborough living in rented housing and only 2% living in shared rented accommodation.
- It is very difficult to access affordable housing for newly arrived migrants from EU countries. 17.2% of the current applications for social housing were made by people from A8 countries
- The numbers of Eastern European rough sleepers have sharply increased over the last 12 months and currently there are around 24 Eastern European rough sleepers on any night in Peterborough. These people may have multiple and complex needs including alcohol abuse.
- A selective licencing scheme has been approved locally for Peterborough within 22 Lower Super Output Areas. This will help to ensure greater enforcement of accommodation standards in relation to private rented accommodation and houses of multiple occupancy (frequently used by the Eastern European migrant population)

National research on migration and accommodation

Data from Oxford University's Migration Observatory[58] show that there are several observed key distinctions between migrant populations and UK-born populations in 2015:

- Only 43% of migrants own their own homes, compared to 68% of UK-born residents.

- The UK's migrant population is almost three times as likely to be in the private rental sector (39% of migrants were in this sector in quarter one 2015, compared to 14% among the UK-born population).

- Migrants who have been in the UK for five years or less are almost twice as likely to be renters compared to all migrants, with 74% of people within this group renting. Where

[58] Vargas-Silva, C., Migrants and Housing in the UK: Experience and Impacts, 2015

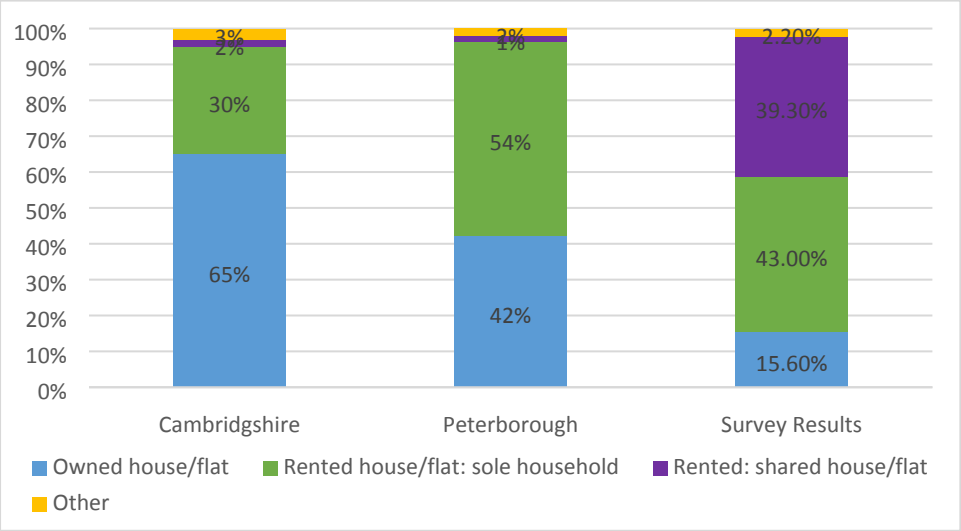
migrants have been in the UK longer than five years, patterns of ownership are relatively similar to that of the UK-born population.

- 17% of the UK-born population live in social housing, compared to 18% of the non-UK born population.

Accommodation used by Eastern European migrants locally

The Community survey asked a question about accommodation. The results are shown in the figure below and reinforce the key findings from Oxford University's Migration Observatory above. 82% of migrants who answered the survey question live in rented accommodation, with 39% living in shared rented housing.

Figure 56: Cambridgeshire and Peterborough Community survey results for accommodation type. Comparison between the proportions of migrants and the proportions of the general population in Cambridgeshire and Peterborough using different types of accommodation



Source: Cambridgeshire & Peterborough Migrant Healthy Survey 2015/16

The results also show that a much smaller proportion of migrants are owner occupiers compared to the general population.

Housing quality

Living conditions tend to be poorer in shared rented houses, particularly in houses of multiple occupation (HMO), where issues related to overcrowding may arise. HMOs of poor standard may present health hazards, for example problems with damp and mould can affect respiratory systems, problems with pests such as rats, mice or cockroaches can create unhygienic environments and spread diseases. A cold home that lacks effective heating and insulation could affect health, particularly in vulnerable people.

Safety hazards in the home may include fire risks, faulty wiring and the risk of carbon monoxide poisoning.

A Peterborough study on the local migrant population (2009) assessed the views and experiences of migrant workers in terms of a range of factors, including accommodation in predominant migrant groups to Peterborough in 2008/09 – Polish, Czech, Slovak, Portuguese and Lithuanian communities.

The research showed a dominance of the private rented sector amongst the migrant population of Peterborough - 51% of 278 migrant people interviewed were renting through private landlords. Almost half of these said they had no tenancy agreement.

There were 60 cases of bedrooms being shared by more than three people. Issues highlighted by the survey included problems with landlords, particularly in relation to conditions of properties. The condition of properties was also an issue creating tension between migrant communities and other local residents.

A recommendation that came from this research was the need to ensure greater enforcement of accommodation standards in relation to private rented accommodation.

Local Authority housing

Data from Peterborough City Council –housing showed that 17.2% of the current applications for Local Authority housing (all EEA countries including British) were made by people from A8 countries. 550 applications currently on the housing register were from residents from A8 countries out of a total of 3201 registrations for housing.

Homelessness in the Eastern European population

15.4% (20/130) of people who answered the local migrant survey said they had been at risk of homelessness. The Peterborough migrants study (2009) found that lower skilled migrants are more vulnerable to homelessness; however, anecdotal evidence also suggests that some people will opt for living in tents as a cheap means of accommodation.

In 2010, Peterborough recorded one of the highest rates of rough sleeping outside Westminster, with around 60 people sleeping on the streets at any one time, many of whom were Eastern Europeans. A response to this was formed in the development of the 'administrative removal project' between the City Council and UK Border Agency. This project facilitated the 'Administrative removal' of Eastern European rough sleepers who had refused other assistance. Alongside this project the City Council facilitated a 'reconnection project' which enabled those who were sleeping out to return to their home countries with dignity and respect. The running of these two projects saw a decrease in rough sleeping to approximately 15 people per night by 2015. However, the numbers of Eastern European rough sleepers has increased over the last 12 months and currently there are around 20 Eastern European rough sleepers on any night in Peterborough. This increase may be related to changes to welfare benefits for Eastern European nationals in 2014. Alcohol dependency is described as an issue for the majority of Eastern European people who are sleeping rough. The rough sleeper outreach service offers support and signposting to those who are eligible and rough sleeping to enable them to receive support in filling in forms, completing a C.V and helping to find employment. If they are unwilling to engage with services and are not eligible for assistance, they can be served with a notice by the Home Office through the administrative removal project.

Stakeholder feedback

Anecdotal community stakeholder feedback stated that social housing was perceived as cheaper, more secure and reliable than private rented accomodation. Problems for migrants occur when dealing with housing agencies including the requirement for guarantors, permanent contracts and

high application fees. It is difficult for new migrants to access affordable housing. One of the outcomes of this issue is homelessness.

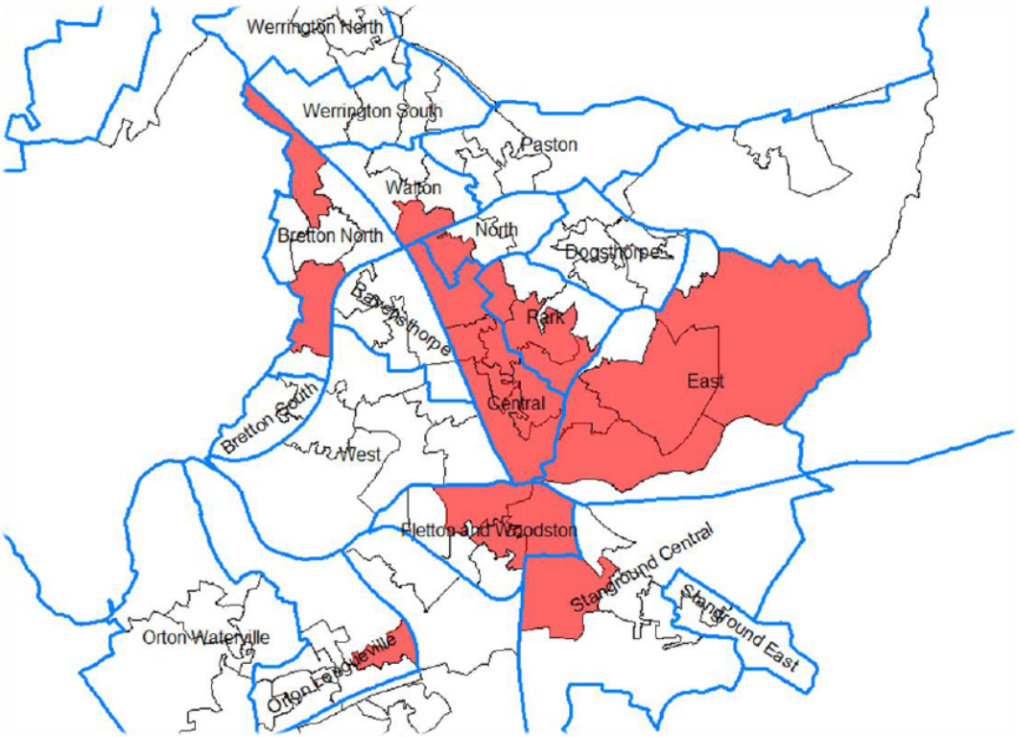
Selective Licencing

The Housing Act 2004[59] has given local authorities the power to introduce selective licensing of privately rented properties to improve conditions for tenants and the local community, if there is a high level of privately rented housing stock in the area and one or more of the following criteria are met:

a) The area is suffering from low housing demand
b) The area is experiencing a significant and persistent problem caused by anti-social behaviour
c) The area is suffering from poor property conditions
d) The area has high levels of migration
e) The area has high levels of deprivation
f) The area has high levels of crime

In Peterborough, the City Council Cabinet has approved selectively licensing within 22 Lower Super Output Areas (geographical areas with an average of 1,500 residents) in the Central, North, East, Park, Fletton, Bretton North, Stanground Central, Walton and Orton Longueville areas. These areas are known to have high proportions of Eastern European residents (data from census and school census). The scheme is proposed to cover 6,205 properties representing 4.8% of the city's geographic area and will initially last for five years.

Figure 57: Peterborough City Council – Proposed Selective Licensing Areas



Source: Peterborough City Council, Adult Services & Communities Directorate

[59] http://www.legislation.gov.uk/ukpga/2004/34/contents

Selective Licensing in Peterborough also needed national government approval from the Secretary of State to proceed, and this was granted in August 2016. Upon introduction, it will mean that all private landlords with residential property in designated areas will need to apply for a licence for each property. A landlord will need to meet a certain standard to become a licence holder and the licence will last for five years.

By introducing Selective Licensing, it is hoped that the quality, management and safety of all private rented properties in the designated areas will improve.

7.5 Specific Recommendations

In addition to the general recommendations made in Section 6 of the main Diverse Ethnic Communities JSNA (page 48), the following specific recommendations are made to support the health and wellbeing of Eastern European communities in Peterborough, based on the information in this Appendix. Some of these recommendations are similar to those made in a recent Migrant and Refugee JSNA for Cambridgeshire, so there may be scope for joint work across both Councils and the Cambridgeshire and Peterborough Clinical Commissioning Group to address them.

Recommendations for addressing need in the Eastern European migrant population in Peterborough

- Assess current information available to new migrants and create an up-to-date 'information' pack in appropriate languages that covers childcare, nurseries, school admissions, the health system, the tax system, housing, employment and benefit rights, and other useful local information. This 'pack' should be accessible online or through social media, potentially using video and the spoken word as well as written information. Dissemination and awareness raising of the information pack should be through public sector bodies including schools as well as through employment agencies and community forums for Eastern European residents. This recommendation is similar to one made in Cambridgeshire, giving scope for joint work. In Cambridgeshire the need of some local UK-born residents for clear verbal and simple written information on these issues was also highlighted – so it was agreed that the materials developed should be designed to be useful to new migrants and to other local residents.
- Continue the role of Peterborough City Council's 'community connectors' from Eastern European communities, to help disseminate information including the 'information packs' and build trust between communities.
- Improve appropriate use of primary care and the GP offer for A8 migrants – review primary care services for migrants taking into account issues around access, trust, communication difficulties and referral pathways. Further explore health beliefs of Eastern European migrants to understand cultural differences
- Improve opportunities for English language classes - Review current availability and funding to identify gaps and opportunities, taking into account the 'unsocial' hours many migrants work

Annex 1 - Results of Community Health Survey

The Public Health departments of Cambridgeshire & Peterborough ran an open survey in quarter 4 2015/16 to ask predominantly Eastern European migrant communities about their experiences of issues including housing, employment and public services in the UK. The survey was advertised via the Cambridgeshire County Council and Peterborough City Council websites, social media accounts and via local promotion through key stakeholders such as the Rosmini Centre in Wisbech and Community Connectors employed by Peterborough City Council. The survey was available electronically and in paper-based formats in English, Polish and Lithuanian and help with translation was made available to anyone who required it. Key findings and full results are presented below:

Key Findings:

- **The majority of survey respondents are originally from Lithuania (39.9%), Poland (22.9%) or Latvia (17.6%). 61.0% of respondents (94 people) are aged 31-45 and 84.3% (129 respondents) are female. Additionally, 46.6% respondents stated they had attended a university. 61.7% of respondents (82 people) live in Peterborough and 51 people (38.3% of respondents who answered the question) live in Cambridgeshire.**

- **Whilst interpreting these survey results, it should be acknowledged that the response data will, by definition, provide findings that relate only to people sufficiently engaged with local government/local services to wish to complete a survey of this nature and be sufficiently literate to do so in either English, Polish or Lithuanian. Paper copies were provided upon request so it is not necessarily the case that the results are biased towards the ICT-literate, although the survey was only publicised to the general population electronically, via Cambridgeshire County/Peterborough City Council websites and Facebook. For the aforementioned reasons, results may therefore not be representative of migrant populations with particularly high levels of aversion to involvement with government/local authorities, high levels of deprivation and/or low levels of literacy.**

- **93.0% of respondents said they were registered with a GP practice, compared to only 60.6% registered with a local dental practice. 81.1% of people said they had visited a local hospital since arriving in England.**

- **Although 85.7% of respondents stated that their level of spoken English at least allowed them to participate in simple conversations and 87.1% said their level of written English allowed them to at least understand simple instructions, only 72.8% of respondents said that their understanding of UK healthcare services was 'reasonable' or 'good'. Respondents were asked to rate GP services on a scale of 1-5 (1 = very bad, 5 = very good) and for all categories, the average score provided was at least 3.1/5; when the same questions were asked about local hospitals, average scores were higher, ranging between 3.9 and 3.3. Respondents scored 'patient communication and respect' 3.1/5 for GPs and 3.9/5 for hospitals, suggesting a degree of variation with regards to this measure between GPs and hospitals. For maternity services, average scores were higher than for GPs and hospitals, ranging from 4.2/5 for accessibility and patient communication and respect to 3.8/5 for time effectiveness.**

- **48.4% of survey respondents said they had not made any appointments for screening or immunisation with their local doctor/GP service and only 27.8% of applicable respondents (people aged 40-74) have had an NHS health check.**

- **75.7% of respondents said they did not smoke cigarettes and 54.8% said they did not drink any alcohol, which may be a reflection of the mainly relatively highly educated, female and young population that responded to the survey, as epidemiological evidence from Europe suggests that rates of alcohol and tobacco consumption, as well as associated disease prevalence, are higher in Eastern European countries than in England.**

- **73.4% of survey respondents said they were employed and, when asked to rate their working conditions on a scale of 1-5 (1 = very bad, 5 = very good), respondents scored 'treatment and respect' 3.8/5, working hours and working conditions 3.7/5 and opportunity for advancement and wage 3.4/5. 36.1% of respondents said they had obtained their current employment via an employment agency.**

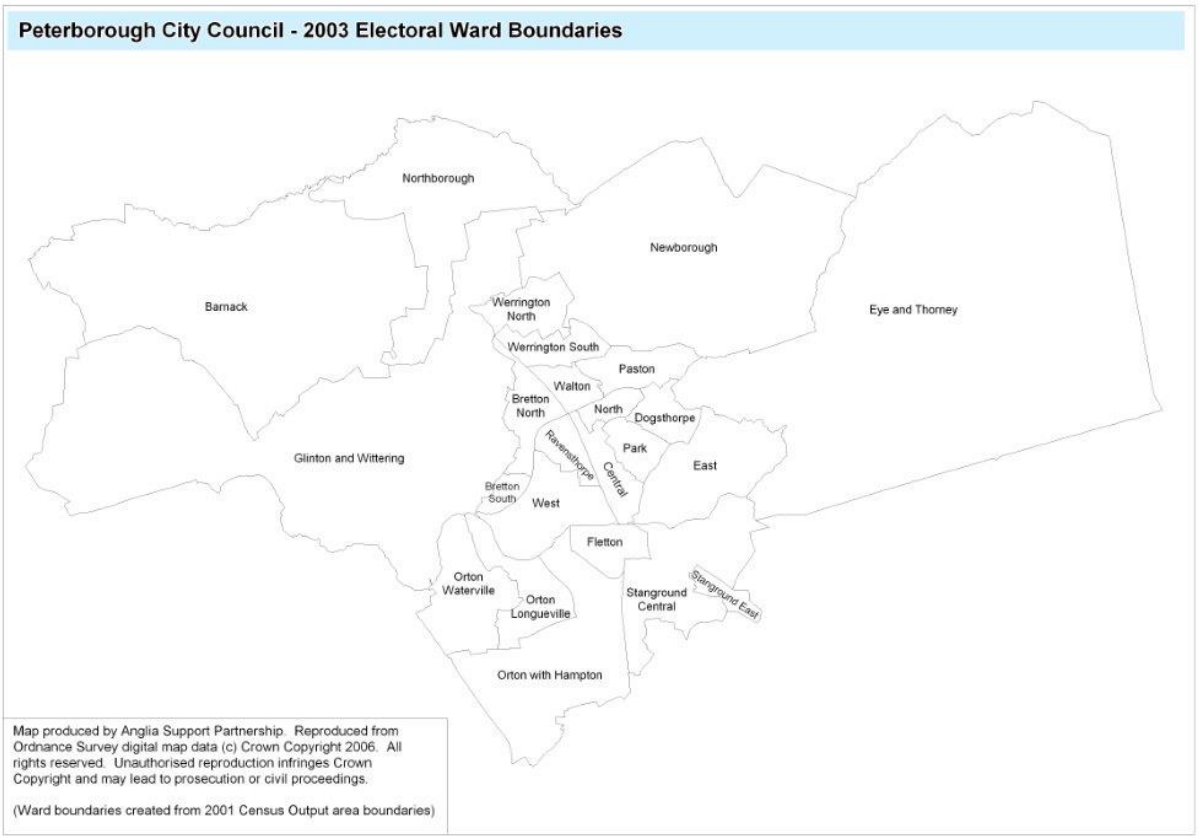
- **55.2% of people said they felt community services were accessible but only 49.5% said that the services provided are effective.**

- **61.9% of people said they had no worries about their safety at work, with 38.1% expressing at least some reservation about workplace safety. Conversely, 63.1% said they did worry about their safety at least 'sometimes' in their living environment, with only 36.9% saying they had no worries.**

- **Only 32.9% of respondents said they had used a translation service, but of those who had, the average response for overall service on a 1-5 scale (1= very bad, 5= very good) was 4.0/5.**

- **65.2% of respondents said they had been living in the UK for at least 5 years and 52.6% said they intended to reside in the UK permanently. Only 1.3% said they had conclusive plans to leave the UK within the next year. Only 15.6% of people said they owned the property within which they lived (either outright or with a mortgage), with the remaining 84.4% renting/room-sharing. 74.0% of respondents said they had lived in the current accommodation for at least one year.**

Appendix B - Peterborough City Council Electoral Ward Boundaries 2003-2016



Note: Data used in this JSNA uses electoral ward boundaries from 2003-2016 as illustrated on the above map.

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