

**Diverse Ethnic Communities Joint  
Strategic Needs Assessment for  
Peterborough – South Asian  
Communities Supplement**

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We are grateful to all those involved in the publication of the Diverse Ethnic Communities Joint Strategic Needs Assessment for Peterborough (2016) and subsequent survey of the South Asian communities in Peterborough.

## Executive Summary

### General Health

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, including South Asian communities. Emergency hospital admissions are higher than the Peterborough average for these wards but elective (planned) admission rates are lower.

Nationally, mortality is higher for Pakistani infants compared to other ethnic groups. Low birth weight is also more prevalent amongst the South Asian communities compared to the national average.

People with a South Asian ethnicity have a 50% higher lifetime risk of developing type 2 diabetes than white Europeans.

Much of the risk associated with developing diabetes is related to lifestyle, such as diet and physical inactivity. Other factors may be important such as genetics or the way fat is stored and metabolised. Help seeking behaviour and language barriers may also help explain the higher incidence.

Overall, the South Asian population have a lower incidence of cancer than the white population. There are exceptions however. Liver cancer is more prevalent in the South Asian community, as is mouth cancer for females and cervical cancer for females over 65yrs.

*Local survey results found that the top 5 conditions that participants worried about were diabetes (11%) and having excess weight (11%). Heart disease (9%) High cholesterol (9%), high blood pressure (8%)*

### Screening

Nationally, uptake of screening for breast cancer, cervical, bowel and colorectal cancer is lower in the South Asian community than the population as a whole.

*Local survey results show that 33% of respondents who said that they had been offered a smear test either hadn't attended or didn't intend to. 35% of women thought that they hadn't been offered a breast examination or weren't sure. For bowel cancer 42% of those eligible thought that they hadn't been offered an appointment or weren't sure*

### Organ Donation

Although members of the South Asian Community are at higher risk of needing organ transplants, the proportion donating organs is lower than the general population.

### Communicable Disease

The highest rates of tuberculosis are found among people of Indian, Pakistani and Bangladeshi ethnicity who were born outside the UK. The numbers affected in the East of England have reduced significantly since 2011.

### Mental Health

Nationally, the proportion of Asian/Asian British women reporting a common mental disorder (CMD) is higher than the female population as a whole (29% and 21% respectively). Asian men are more likely than white men to report a psychotic episode in the past year.

*The local survey found that depression and anxiety is also something that people experience and worry about (10% and 8% of respondents respectively). A small but significant proportion of respondents do not have access to help (13%) or the ability to meet with friends/ family socially (5%).*

### Obesity, physical activity and diet

By Year 6 levels of obesity are significantly higher for children of Indian, Pakistani and Bangladeshi ethnicity than for England as a whole (37%, 41%, 44% and 34% respectively).

*The local survey found that a significant mismatch between those adults considering themselves to have excess weight (12%) and those who are overweight (65%).*

Nationally, the prevalence of risk factors for obesity, diabetes and heart disease are higher in the South Asian community compared to the population as a whole. For example, a lower proportion of Asian adults are physically active than the general population and eat 5 portions of fruit or vegetables per day.

*Approximately 16% of survey respondents report never achieving 30 mins exercise during a typical week. Approximately 26% do more than 120mins exercise/ week and 11% achieve 30 mins/day.*

*8% of those surveyed meet the recommendation '5-a-day' for consumption of fruit and vegetables. Females are more likely to be consuming more than two portions a day. The national Active Lives Survey estimated 57% of the population in Peterborough were meeting the '5-a-day' recommendation.*

### Smoking

Nationally, levels of smoking in the Asian community are lower than the general population (9% vs 15%). Smoking prevalence declines with age.

*Local survey data found very few female smokers. 15% of those under 65 reported smoking. Half of the 8 people over 65yrs reported smoking.*

### Perceptions of Health and Seeking Help

*Overall, 72% of respondents felt their health was 'good', 'very good' or 'excellent'. 9% rated their health as poor. This was similar between men and women.*

*Very few (2%) reported that they had wanted to seek medical attention in the past year but were unable to.*

*Physicians/doctors were the most common source of information, followed by family and friends. 60% of 18-24yr olds and 50% of 25-44yr olds use the internet, compared to 43% of 45-65yr olds.*

### Safety and Access to Community Services

*The vast majority of survey respondents feel safe at home or in the community most or all of the time (94% and 84% respectively).*

*Use of community facilities (swimming pool, libraries, parks) are comparable with usage amongst the general population.*

## Employment and Income

Members of South Asian communities are less likely to be economically active than white British residents. This disparity is particularly notable for Pakistani women, of which nearly 80% are economically inactive.

Nationally, 35% of people living in households headed by someone of Pakistani or Bangladeshi ethnic origin are living on a low income compared to 14% of the White population.

Nationally 20% of children live in a low income family. For children from Pakistani and Bangladeshi communities this proportion is more than double.

## 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. In 2016 Peterborough City Council published a Joint Strategic Needs Assessment (JSNA) which provided a framework for identifying and understanding the needs of diverse ethnic communities in Peterborough<sup>1</sup>. A key recommendation from this JSNA was to provide a supplement to the report focussing on the needs of the South Asian community.

This supplement provides information on the demography, education and health of the South Asian population in Peterborough, using local and national quantitative (numerical) data, together with national research, to provide information on the likely health and wellbeing needs of this community.

The data available comes from a number of sources, including national surveys and contact with health services. Data relating to ethnicity falls into 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. 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 and planners allocate resources.

It's also important to understand the views and experiences of diverse communities, and of wider stakeholders which provide services and so a local community survey and focus group was undertaken to inform the JSNA. This is described in more detail below and the results are presented throughout the report.

## Ethnicity and Health

Ethnicity has been described as “a form of collective identity that draws on notions of shared ancestry, cultural commonality, geographical origins and shared biological features”<sup>2</sup>. For the purposes of this report the phrase 'of South Asian Community' is used to mean people with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka.

Ethnic identity can have an influence on health outcomes through a number of routes. For example, experiences of discrimination and exclusion, as well as the fear of such negative incidents, have been shown to have a significant impact on mental and physical health. Health-related practices, including healthcare-seeking behaviours, also vary importantly between ethnic groups<sup>3</sup>.

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<sup>1</sup> Diverse Ethnic Communities Joint Strategic Needs Assessment for Peterborough, 2016. Available at <https://www.peterborough.gov.uk/healthcare/public-health/JSNA/>

<sup>2</sup> Salway S, Carter L, Powell K, et al. Race equality and health inequalities: towards more integrated policy and practice. Race Equality Foundation Better Health Briefing Paper 32. Race Equality Foundation 2014:4

<sup>3</sup> Local action on health inequalities Understanding and reducing ethnic inequalities in health. PHE 2018.

Unfortunately, the quality of data relating to ethnicity is very variable. For example, although research suggests that uptake of screening programmes is low in some communities, no local data is available to examine this in detail. The small numbers in some local populations can make it hard to analyse data effectively, particularly if one then wants to examine differences by age or gender.

## South Asian Community Survey and Focus Group

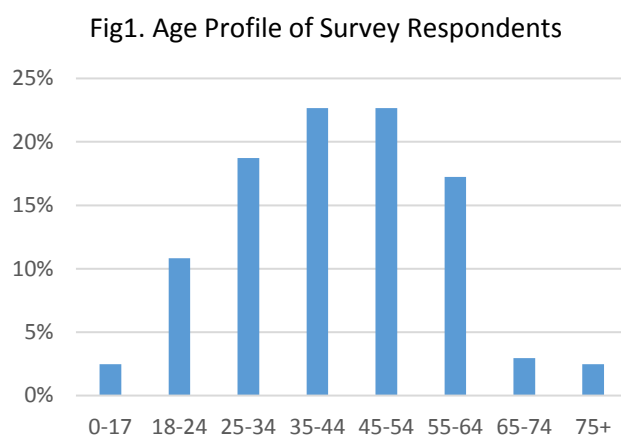
The development and administration of the survey was led by the Public Health Team in association with colleagues from the Councils' Community Resilience and Integration team and healthy lifestyles provider, Solutions4Health. The survey took the form of a structured interview and was completed by volunteers using a number of routes, including attendance at Mosques and other community events.

See Appendix 1 for full details of the questionnaire.

### Survey Respondents

The survey was completed by 249 people.

- Where gender was recorded (90% of respondents), 53% were male and 47% female
- The age profile of respondents is shown in Fig 1.



- Where faith was recorded (87% of respondents), 82% were Islam/Muslim, 13% Hindu, Christian (3%), Sikh 1%, Christian and Muslim 1%
- Where primary language was recorded (78%), 38% spoke English, 27% Punjabi, 8% Urdu, 6% Gujarati, 3% Urdu/Punjabi, 3% Bengali, 3% Dari Pashto, 2% Telugu, 2% Tamil. A number of other languages were spoken by 2 or fewer people.<sup>4</sup>
- Where marital status was recorded (90%), 73% reported being married
- Of those reporting how long they had lived in the UK (88%), 48% had lived here all their lives. 48% had lived here more than 5 years but were born elsewhere.

<sup>4</sup> Tagalog/English, Hindi/English, Tagalog, Hindi, Kiswahil, Malayalam, Kannada



- Where employment status was recorded (88%), 66% reported being employed, 9% unemployed but not seeking work (e.g. caring for children), 5% unemployed and seeking work, 8% students, 8% retired, 3% carers, 1% unable to work due to illness.

It is important to view the results of the survey with these demographic characteristics in mind. The majority of respondents were of Islamic faith, married and long term residents of the UK. There are few responses from the unemployed, new arrivals to the country and those under 18 or over 65 years old. As a consequence it may be useful to complete further work targeted to these groups within the community.

**Recommendation:** Consider further work to explore the health needs of young people and the older population.

### [Focus Group](#)

A focus group was also undertaken with a sample of women in community worker roles within the South Asian Community. Six women participated, five of whom were Pakistani and one White British ethnicity. The session was facilitated jointly by members of the Public Health Team and Solutions4health. Discussion points are interspersed within the main report.

### Demography

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 and planners on where best to direct resources in order to address any need identified for particular ethnic communities.

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. Unfortunately more recent data is not available from other sources.

Table 1 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.

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

Peterborough - 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

Peterborough experienced big changes in its ethnic profile between the two census in 2001 and 2011. See Table 2. In terms of overall numbers, the population of Peterborough increased by 17.7% between 2001 and 2011. Whilst the Asian population experienced large percentage increases, the biggest change was within the ‘white other’ group and the Black British or Black African category.

As a proportion of the total population in Peterborough, the black or black British population (African or Caribbean) still accounted for less than 1.5% in 2011. Between 2001 and 2011, as a proportion of the total population,

- White British decreased from 86% to 71%
- White ‘other’ increased from 3% to 11%
- Asian or Asian British –Indian increased from 2% to 3%
- Asian or Asian British - Pakistani increased from 4% to 7%

**Table 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	17.7%	-2.6%	340%	115%	61%	73%	5.2%	350%	64.2%

### 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 table 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.

**Table 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
<b>Peterborough UA</b>	<b>17.5</b>	<b>27.7</b>
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
Glington 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 table below shows the proportion of the population of each (pre-2016) electoral ward in Peterborough in each ethnic 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.

**Table 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 ethnicities 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.

## Health Profile

### Mortality

Health impacts relating to country of origin

Describing the health of a population by country of birth is important as it represents a dimension of inequality in its own right and highlights significant health inequalities. It is not the same as considering ethnicity, as people born in the same country will identify with a number of ethnic groups and a substantial proportion of those from minority ethnic groups are born in the UK.

Data in Table 5 below shows mortality rates for common diseases according to countries of birth. It is likely that the influence of country of birth on health will depend on a number of factors including length of residence, age and socio-economic status.

It should be noted also that 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.

**Table 5: 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
UK	4.2	111.8	16	130.4	30.5	6.2

Orange 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.
- Mortality from cardiovascular disease is higher in India and Pakistan than in the UK
- Cancer mortality rates are lower in the south Asian countries, compared to the UK
- Mortality from respiratory disease is high in the Asian countries listed
- Mortality rates from suicide are higher in India compared to the UK

Analysis conducted by Public Health England using ONS death registration data and the 2011 census data found a significantly worse cardiovascular disease mortality rate for both men and women born in India, Pakistan and Bangladesh compared to residents of England as a whole. The only exception were males born in India. The same analysis found that mortality rates from suicide and cancer were significantly lower for those born in India, Pakistan and Bangladesh compared to English residents.<sup>5</sup>

#### [Inequalities within Peterborough – mortality rates by electoral ward](#)

Table 6 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

<sup>5</sup> Public Health Outcomes Framework: Health Equity. Focus on ethnicity. Public Health England 2017.

and these wards have high levels of deprivation (apart from West ward). Deprivation is associated with risk factors for cardiovascular disease, including smoking prevalence, obesity and physical inactivity.

**Table 6 – 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

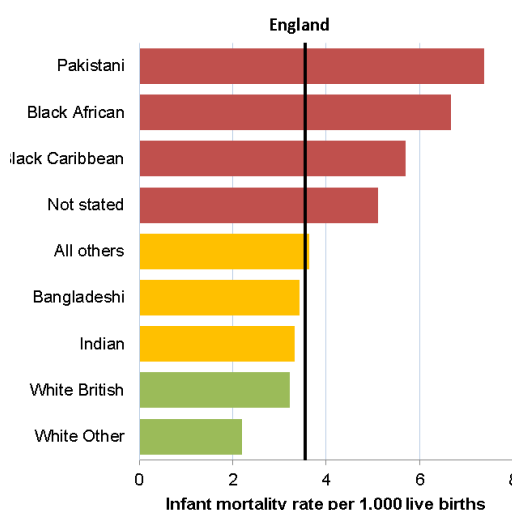
Red indicates rates higher than Peterborough average and green indicates rates lower than Peterborough average.

### Infant Mortality

Infant mortality is defined as the rate of deaths in infants aged under one year per 1,000 live births. It is a recognised ‘barometer’ for the health of the entire population and reflects many of the ‘upstream’ determinants of population health such as economic, social and environmental conditions.

For England as a whole, infant mortality rates have fallen over time, from 5.4 deaths per 1,000 live births in 2001-03 to 4 deaths per 1,000 live births in 2012-14. However, wide inequalities remain and rates vary considerably by ethnic group. In 2014, the Pakistani, Black African, and Black Caribbean ethnic groups, and those whose ethnic group was not stated, had significantly higher rates of infant mortality than England as a whole<sup>6</sup>. See Fig 2.

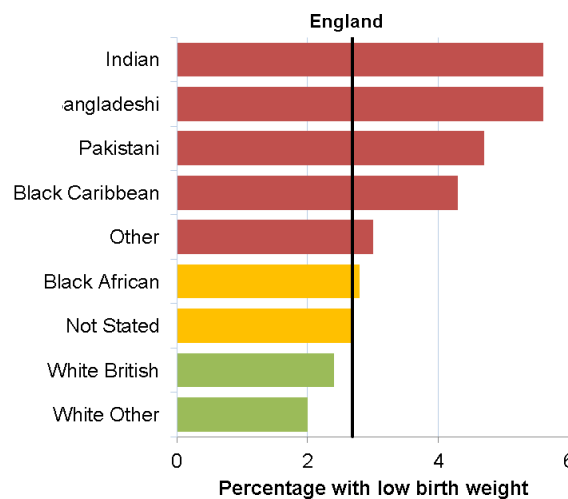
**Fig 2. Infant Mortality in selected ethnic groups, England, 2014.**



<sup>6</sup> Public Health Outcomes Framework: Health Equity. Focus on ethnicity. Public Health England 2017.

Low birth weight<sup>7</sup> increases the risk of childhood mortality and of developmental problems for the child, and is associated with poorer health in later life. A high proportion of low birth weight births could reflect issues with maternity services and/or behavioural factors of mothers. The proportion of low birth weight babies varies by ethnic group. In 2015, Indian, Pakistani, Bangladeshi, Black Caribbean, and Other ethnic groups had significantly higher proportions of term babies born with low birth weight than England as a whole<sup>8</sup>. See Fig 3.

**Fig 3. Low birth rate in selected ethnic groups, England, 2015**



### Cardiovascular disease (CVD) and ethnicity

Peterborough CVD JSNA 2015<sup>9</sup> contains a section describing risk of cardio-vascular disease associated with ethnicity.

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, 20106), 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 exist between ethnicities with regard to access to treatment, (Heart UK, 2013) 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 in the incidence of admissions for CVD in the BME ethnicities compared with the white British community. However, there is a high

<sup>7</sup> Live births with a recorded birth weight under 2,500g and a gestational age of at least 37 complete weeks (full term) as a percentage of all live births with a recorded birth weight and a gestational age of at least 37 complete weeks.

<sup>8</sup> Public Health Outcomes Framework: Health Equity. Focus on ethnicity. Public Health England 2017.

<sup>9</sup> <https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/healthcare/public-health/CardiovascularDiseaseJSNA-November2015.pdf?inline=true>

proportion of ethnicity described as 'not known' in the data which is likely to make the results unreliable.

### Diabetes and ethnicity

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.<sup>10</sup>

As with cardiovascular disease, much of the risk associated with developing diabetes is related to lifestyle, such as diet and physical inactivity. Research also suggests that other factors may be important such as genetics or the way fat is stored and metabolised. Help seeking behaviour and language barriers may also help explain higher incidence of diabetes in the South Asian community<sup>11</sup>.

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.

### Community Survey Result

Diabetes was a top concern for those surveyed (12% of respondents) and one of the most prevalent conditions included within the survey (11% of respondents).

### Focus Group Result

Diabetes is a concern, however diseases such as these may be perceived by some as 'God's will' rather than preventable through lifestyle choices. People are less likely to be frightened by the prospect of diabetes in comparison to cancer.

### Variation in cancer incidence by ethnicity – evidence from the literature

BME groups have lower risk of cancer in general than people of white ethnicity.<sup>12</sup> 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

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<sup>10</sup> Obesity: identification, assessment and management. Clinical guideline [CG189] November 2014 and Weight management: lifestyle services for overweight or obese adults Public health guideline [PH53] May 2014

<sup>11</sup> Diabetes UK and South Asian Health Foundation recommendations on diabetes research priorities for British South Asians. Diabetes UK (2009)

<sup>12</sup> Cancer Incidence and Survival By Major Ethnic Group, England, 2002-2006 & National Cancer Intelligence Network, 2015



Asian females, for those aged 65 and over, but lower in Asian females below the age of 65, when compared with white females.

Asian 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.

### Variation in cancer survival by ethnic group

Cancer survival by ethnicity was also analysed in this report and found that 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 with lung cancer aged over 65-99 had improved outcomes for lung cancer at both one and three years than White ethnicities for all ages.

### Cancer screening

Although there are no local data that examines the variation in cancer screening uptake by ethnicity, the research literature provides evidence that uptake of 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, Lee et al. 2010a, Lofters et al. 2010)

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) 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).

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.

### Community Survey Result

Fig 4 below shows how the respondents, falling within the relevant age criteria answered when asked about cancer screening. Results for each screen are described below.

**Note:** *it should be noted when interpreting the data below that the numbers of eligible respondents who answered each question was low (smear test = 70, breast examination = 28, bowel screen =12). Therefore the results may not truly represent to the local community as a whole. However they are useful in identifying future lines of enquiry.*

## Smear Test

Fig 5 shows that 54% of women have attended or intend to attend an offer of a smear test. According to NHS data, cervical cancer screening coverage in Peterborough during 2017 was 70%, however direct comparisons between these estimates is not possible due to the way the data was collected and the small number of respondents to the local survey. Perhaps of more concern are the 33% of respondents who said that they had been offered an appointment but either hadn't attended or didn't intend to. A further 13% said that they hadn't been offered or weren't sure whether this was the case.

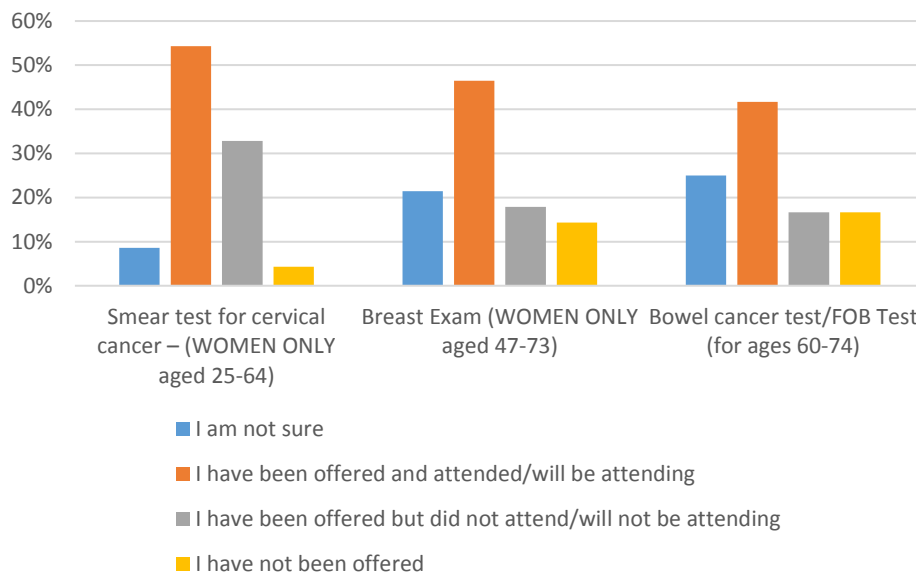
## Breast Examination

46% of respondents have attended or intend to attend an offer of a breast examination. According to NHS data, breast cancer screening coverage in Peterborough during 2017 was 74%. Again direct comparisons between these estimates is not possible due to the way the data was collected and the small numbers of respondents to the local survey. It is notable however that 35% of women thought that they hadn't been offered a screen or weren't sure.

## Bowel Cancer Screening

Only 42% of respondents said that they had attended or will be attending screening, having been offered it. Coverage of this screening nationally and locally is also low (59% and 54% respectively in 2017). Whilst a relatively low proportion (17%) said that they hadn't/wouldn't be attending an appointment which had been offered, 42% either weren't sure or hadn't been offered a screen.

**Fig 4. In the past five years, have you been offered and/or attended any of the following? (Select all that apply)**



## **Focus Group Result**

The participants highlighted that some women may not attend cervical screening appointments if they are not married. This is due to a belief that they will 'lose their virginity' through the process.

They may also think that they shouldn't be exposing themselves. There is also a need to dispel myths in relation to bowel screening.

### 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<sup>17</sup>). The study suggests the need for culturally sensitive, community-based interventions to raise awareness and encourage early presentation.

### Organ/Blood Donation

According to the NHS Blood and Transplant Service more donors from black, asian and minority ethnic groups are urgently needed to address an increase in patients from the same communities dying whilst waiting for an organ transplant. One in five people who died on the Transplant Waiting List last year were from a black, Asian or ethnic minority background<sup>13</sup>.

Recent research found that almost a third of black and Asian people in England are unsure about donating their organs for lifesaving transplants after their death. A higher proportion - 37% - said they did not want to be an organ donor. Just 11% of those surveyed said they would definitely donate, while the remainder would consider it. The main barrier is the belief that organ donation is against their culture or religion. However, all the major religions in the UK support organ donation and transplantation.

Just 1 in 5 of those surveyed were aware that organs matched by ethnicity had the best chance of success. Only 1 in 10 knew that people from black, Asian and ethnic minority backgrounds are more likely to need an organ transplant than white people.<sup>14</sup>

### Communicable Diseases

Tackling tuberculosis (TB) is currently one of the key priorities of Public Health England. The highest rates of disease are found among people of Indian, Pakistani and Bangladeshi ethnicity who were born outside the UK. While reactivation of latent infections acquired outside the UK accounts for much of the disease burden, there is evidence that transmission within established communities in the UK may be an increasing issue, particularly among South Asian communities<sup>15</sup>.

The rates of TB among people born outside the UK should be interpreted in the context of changes to the pre-UK entry screening policies. In 2005 the UK piloted the pre-entry screening of long term migrants to the UK for active pulmonary TB in 15 high TB incidence countries. In 2012 this pre-entry screening was extended to all countries with a high incidence of TB (>40 cases per 100,000 population).

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<sup>13</sup> <https://organdonation.nhs.uk/about-donation/organ-donation-and-ethnicity/>

<sup>14</sup> [https://www.nhsbt.nhs.uk/news/survey-reveals-only-a-minority-of-black-and-asian-people-in-england-are-prepared-to-give-the-lifesaving-gift-of-organ-donation/#\\*](https://www.nhsbt.nhs.uk/news/survey-reveals-only-a-minority-of-black-and-asian-people-in-england-are-prepared-to-give-the-lifesaving-gift-of-organ-donation/#*)

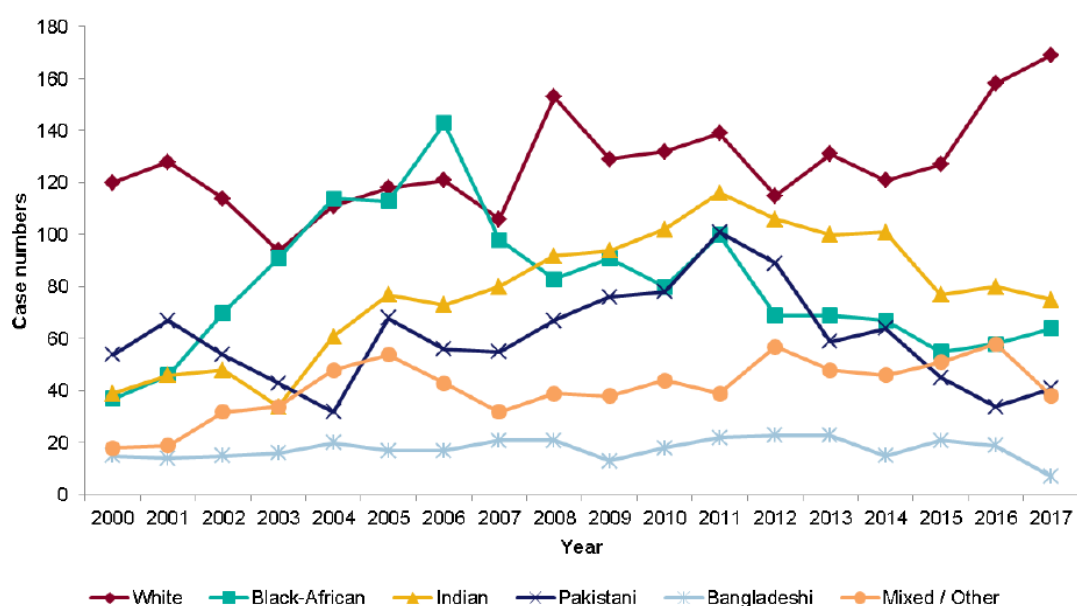
<sup>15</sup> Local action on health inequalities Understanding and reducing ethnic inequalities in health. PHE 2018.

In 2017 98.3% of people with TB had recorded a country of birth (402/409), and of these, 69.2% (278/402) were born outside the UK. The rate of TB was 16 times higher among these people (36.6 per 100,000) compared to UK born people with TB (2.3 per 100,000)<sup>1617</sup>

Amongst TB patients born outside the UK and notified in 2017, the highest number were born in India and Pakistan. This accounted for 22% and 12% of non-UK born cases in the East of England. The median length of residence in the UK was 9 years and 13.5 years respectively.

Numbers of TB cases from Pakistan, India and Bangladesh have fallen significantly since 2011. However whilst there was a slight decline in the proportion of patients originating from India and Bangladesh between 2016-17, there was increase in those from Pakistan. See Fig 5.

**Fig 5. TB case number by ethnic group, East of England, 2000 to 2017**



**Source:** Tuberculosis in East of England: Annual review (2017 data). Data from 2000 to 2017. Public Health England

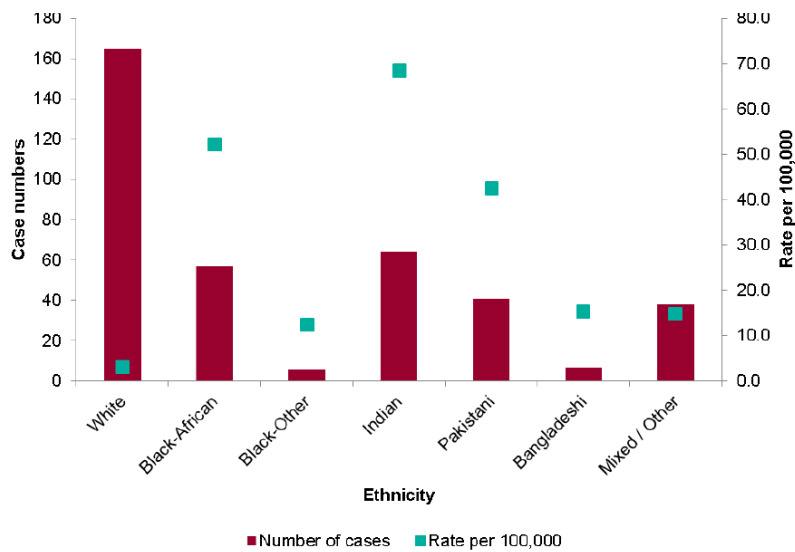
In terms of age, there is a low rate of TB for those under 15 years old. For UK born cases, they are evenly distributed across the remaining age groups (49 cases aged 15-44 years, 38 aged 45-64 years, 33 aged 65 years or more). However, among those born outside the UK, the majority of cases are aged 15-44 years (67.3%, 187/278).

The reporting of TB cases by ethnic group is very good (98.5%). The highest numbers of TB cases in 2017 were white (43.7%). However, the highest rates were seen for Indian (68.5 per 100,000), black-African (52.2 per 100,000) and Pakistani (42.6 per 100,000) ethnic groups. See Fig 6.

<sup>16</sup> Tuberculosis in East of England: Annual review (2017 data). Data from 2000 to 2017. Public Health England

<sup>17</sup> These rates should be interpreted with caution, as population estimates, used as the denominators for UK born and non-UK born groups were calculated using the Labour Force Survey, which is liable to sampling error for small population groups

**Fig 6. TB case number and rate by ethnic group, East of England, 2017**



**Source:** Tuberculosis in East of England: Annual review (2017 data). Data from 2000 to 2017. Public Health England

### Mental Health

Tables 7 and 8 below provide a breakdown of rates of common mental disorders (CMD), psychotic disorders and other selected psychiatric symptoms, according to the national Adult Psychiatric Morbidity Survey 2014. It shows that South Asian women have higher rates of CMD, (which includes depression and anxiety), than other ethnic groups. Rates of psychotic disorder within the male Asian population are higher than white males and the population as a whole.

Anecdotal evidence from the healthy lifestyles provider in Peterborough, Solutions4Health suggests that dementia is growing concern for the South Asian community. This is partly due to a change in the choices being made by the younger generation to leave traditional extended family living arrangements. There is also a degree of stigma relating to the condition which may hinder diagnosis and provision of appropriate support. It is estimated that 65% of people with dementia living in Peterborough and Cambridgeshire have received a diagnosis<sup>18</sup>. Unfortunately this data is not available by ethnic group.

<sup>18</sup>

<https://app.powerbi.com/view?r=eyJrIjojM2Y0ZTUzMDUtMmYzOC00MDUxLWE1YTUtMjRhYzVkZjVlODRjliwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMlslsmMiOjh9>

**Table 7. Age standardised rates of different mental disorder according to ethnicity, adults, 2014.**

	Ethnic group											
	All adults		White British		White Other		Black/ Black British		Asian/ Asian British		Mixed, multiple and other	
	male	female	male	female	male	female	male	female	male	female	male	female
<b>CMD*</b>	13.2%	20.7%	13.5%	20.9%	13.1%	15.6%	13.5%	29.3%	12.9%	23.6%	10.5%	28.7%
<b>Suicide** thoughts</b>	18.7%	22.4%	19.6%	23.5%	23.3%	18.6%	21.4%	20.3%	12.0%	14.3%	9.5%	26.6%
<b>Suicide* attempts</b>	5.4%	8%	5.3%	8.5%	6.0%	6.2%	8.9%	3.9%	5.1%	5.6%	1.5%	10.0%
<b>Self-harm*</b>	5.7%	8.9%	5.8%	10.3%	8.3%	4.3%	5.5%	4.2%	6.1%	4.7%	1.9%	6.6%

\*CMD past week, \*\*lifetime , age standardised

Table 8 . Psychotic disorder in the past year (2007 and 2014 combined), by ethnic group and sex					
	All	Ethnic group			
		White	Black	Asian	Mixed/other
Men	0.5	0.3	3.2	1.3	-
Women	0.6	0.7	-	0.4	-
All adults	0.5	0.5	1.4	0.9	-

### Community Survey Result

There is evidence to show that loneliness is linked to a range of negative health outcomes and risk factors, such as inactivity, smoking, depression and low self-esteem. Feeling lonely can make a person more likely to perceive, expect and remember others' behaviour to be unfriendly. This can increase social anxiety and cause them to withdraw further, creating a vicious cycle. Feeling lonely frequently has a direct impact on individuals and can also have wider effects for society. For example, lonely people are more likely to be readmitted to hospital or have a longer stay.<sup>19</sup>

The survey asked people about the availability of help when sick and for social contact. See Fig 7. It shows that a small but significant proportion of respondents do not have access to help (13%) or the ability to meet with friends/ family socially (5%). However,

<sup>19</sup> A connected society. A strategy for tackling loneliness – laying the foundations for change. HM Government 2018

**Fig 7. Availability of help and social contact**



### Focus Group Result

There is a lack of understanding about dementia with the community and a reluctance (particularly amongst men) to discuss it, due to perceptions of shame. People may find real life examples helpful which they can relate to. There is power in sharing stories. Mental health problems are often a hidden issue for women, where a cultural attitude may persist that low mood is normal and people “just have to get on with things”. This may be compounded by feelings of isolation resulting from a lack of contact with people outside the extended family

## Obesity, physical activity and diet

### Introduction

As well as increasing the risk of developing a whole host of diseases (including diabetes, high blood pressure and heart disease) obesity can harm people’s prospects in life, their self-esteem and their underlying mental health. Research has shown that people who are obese or overweight are less likely to exercise in public as they feel discriminated against because of their weight.

Obesity also has wider and serious consequences for society. The overall cost of obesity to wider society is estimated at £27 billion. The UK-wide NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year.

Obesity, risk of obesity and obesity-related disease differs by ethnic group with some black and Asian populations showing increased risk for obesity and related disease compared with white British groups. (NOO Ethnicity and Obesity, 2011)

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)

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.

The increased risk of obesity-related disease in some ethnic groups is acknowledged in NICE guidance which recommend reducing 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<sup>20</sup>.

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).

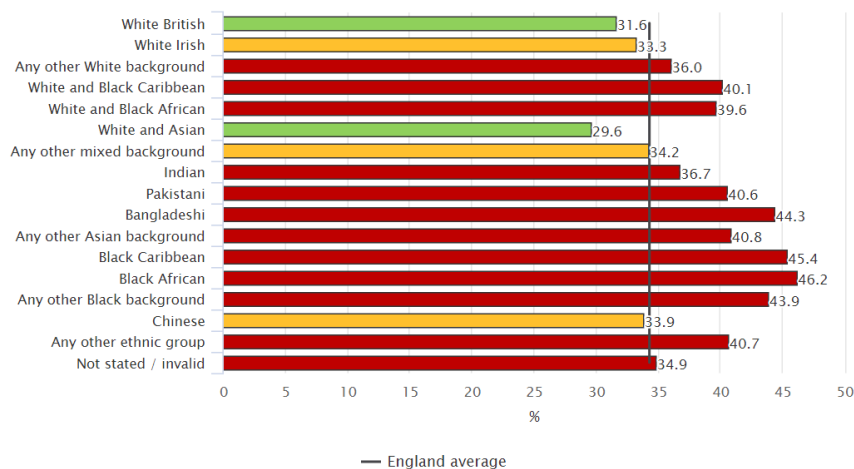
### Overweight and Obesity

In 2016/17, 23% of reception age children in Peterborough were estimated to be overweight (including obese)<sup>21</sup>. This was statistically significantly higher than the average for the East of England (21%). In year 6 (age 10-11), this is far higher (37%) which is again significantly higher than the region (32%).

Data is not available at local authority level by ethnic group, however national data shows that the proportion of reception age children from Indian, Pakistani, Bangladeshi or other Asian backgrounds who are overweight or obese (14.9%, 20.2%, 21.4% and 19.3% respectively) is significantly lower than England as a whole (22.6%).

However by year 6 (10-11 yr olds) the situation has reversed, with the proportion of children from Indian, Pakistani, Bangladeshi or other Asian backgrounds who are overweight (including obese) far higher than England as a whole (34.2%). See Fig 8.

**Fig 8. Year 6: Prevalence of overweight (including obese) England, 2016/17**



<sup>20</sup> Obesity: identification, assessment and management. Clinical guideline [CG189] November 2014 and Weight management: lifestyle services for overweight or obese adults Public health guideline [PH53] May 2014

<sup>21</sup> BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.



By comparison, according to Sport England’s Active Lives (AL) Survey, a lower proportion of adults of Asian ethnicity are overweight<sup>22</sup> than England as a whole (56% and 61% respectively). It should be noted that this data is derived from self-reported height and weight and so may produce different results to the children’s data which is derived from independent direct measurement. However, it has been adjusted using a formula that compensates for some people misrepresenting their weight when reporting it themselves.

### Community Survey Result

12% of respondents indicated that they considered themselves to have excess weight. 11% reported being worried about having excess weight. Based on the self-reported height and weight of survey respondents, it was possible to calculate their BMI. The results were as follows,

BMI	Percentage:
Underweight	4%
Healthy Weight	31%
Overweight	38%
Obese	21%
Morbidly Obese	6%

This suggests a significant mismatch between those considering themselves to have excess weight (12%) and those who do (65%). This disparity is not uncommon in the general population however. According to a recent study using 2013 data from a large nationally representative survey of UK respondents, 55% of adult men and 31% of women failed to identify their overweight weight status<sup>23</sup>.

### Physical activity

According to the Active Lives Survey from Sport England (2016/17), 61.1% of adults in Peterborough were physically active<sup>24</sup> at that time. This is statistically significantly lower than the average for East of England and England (66.8% and 66% respectively). Data regarding particular ethnic groups is not available at local authority level, however national data suggests that a lower proportion of adults of Asian ethnicity are active compared to England as a whole (55% and 66% respectively). This and some older data sources suggest that on average Asian women are less active than men<sup>25</sup>.

<sup>22</sup> Adults with a BMI of 25 or more are classed as overweight, while adults with a BMI of 30 or more are classed as obese.

<sup>23</sup> Robinson E, Oldham M. Weight status misperceptions among UK adults: the use of self-reported vs. measured BMI. *BMC Obesity*. 2016; 3(1): 21.

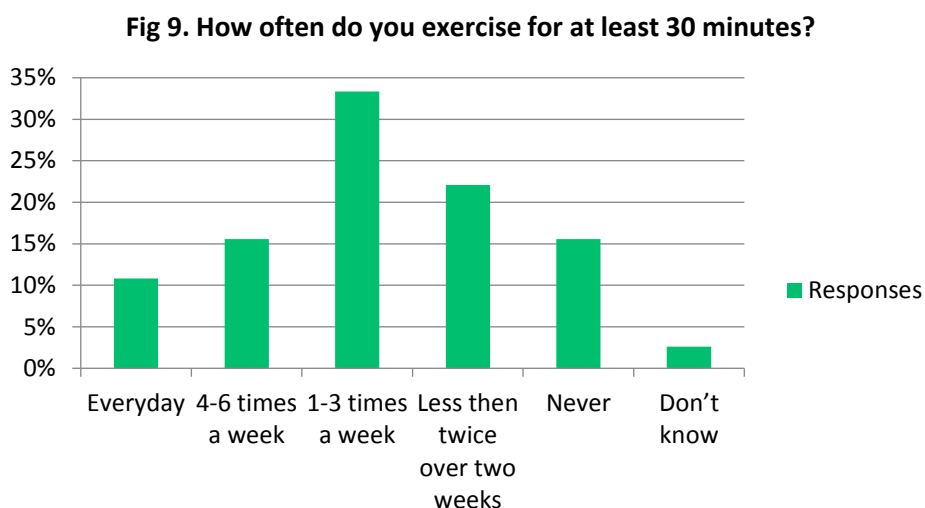
<sup>24</sup> Adults 19 yrs and over doing at least 150 moderate intensity equivalent (MIE) minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days

<sup>25</sup> Health Survey for England (PHE 2004) and Fischbacher C, Hunt S, and Alexander L. How physically active are South Asians in the United Kingdom? A literature review. *Journal of Public Health* 2004;26(3):250-258

The WAY survey of 15 year olds in Peterborough (2014/15)<sup>26</sup> found that 12.7% were physically active<sup>27</sup> for at least one hour per day, seven days a week. This is similar to the average for East of England and England (13.3% and 13.9% respectively). Data is not available regarding the South Asian community in Peterborough, however nationally those of Asian/ Asian British (incl Chinese) ethnic group had statistically lower levels of physical activity than England as a whole (9.5% and 13.9% respectively).

### Community Survey Result

Approximately 16% of survey respondents report never achieving 30 mins exercise during a typical week. This compares to 22% of the population in England as a whole<sup>28</sup>. However, the survey suggests that very few members of the South Asian community are achieving the recommended 150mins of moderate physical activity a day. See Fig 9. Approximately 26% do more than 120mins exercise/ week and 11% achieve 30 mins/day. These more active individuals were split evenly between male and female.



\* exercise is counted as any movement equivalent to or above that of a brisk walk

### Focus Group Result

Lack of exercise for females is a problem. Many women will only exercise in enclosed spaces where no one can see in or out. Sustainability of fitness and weight loss is difficult even if they do attend programmes. They may need support and 1:1 sessions to maintain motivation. Often a husband will need to give permission and the timings are important so that they don't interfere with family

<sup>26</sup> What About YOUth (WAY) survey, 2014/15. <https://digital.nhs.uk/data-and-information/publications/statistical/health-and-wellbeing-of-15-year-olds-in-england/main-findings---2014>

<sup>27</sup> engaged in moderate/vigorous physical activity

<sup>28</sup> <https://fingertips.phe.org.uk/profile/physical-activity/data#page/3/gid/1938132899/pat/6/par/E12000006/ati/102/are/E06000031/iid/93015/age/298/sex/4>

commitments, such as the wife needing to be at home at lunch time when the husband returns home.

## Diet

Poor diet and obesity are leading causes of premature death and mortality (Global Burden of Disease, 2017), and are associated with a wide range of diseases including cardiovascular disease and some cancers, which can have a significant impact on an individual's physical and mental health and wellbeing.

Unfortunately, there are gaps in knowledge regarding the dietary habits of South Asian communities living in the UK and their consequences for health<sup>29</sup>. For example, culinary practice varies widely and it is hard to know the extent to which members of the communities adopt non-traditional diets and whether these are more or less healthy.

There is some evidence of an association between those following traditional diets and higher consumption of fruit and vegetables. In addition, those from South Asian communities (whether UK or non-UK born) are more likely to report eating traditional diets than those from other ethnic groups<sup>30</sup>.

However, whilst some components of traditional South Asian diets are healthy (such as lentils, vegetables and oily fish), the methods of preparation can be very unhealthy, such as deep frying. Large consumption of ghee, which is high in saturated fat and large measures of salt are also linked to poor health<sup>31</sup>.

In 2016/17, 57.2% of adults in Peterborough were meeting the Government's recommended '5-a-day' recommendation. This is similar to the averages for East of England and England (58.2% and 57.4% respectively). Although data relating to ethnicity is not available locally, national data suggests significantly fewer Asian adults meet the recommendation (48.9%).

The WAY survey from 2014/15<sup>32</sup> reported that 50.1% of 15 year olds in Peterborough were meeting the Government's recommended '5-a-day' recommendation. This is similar to the average for the East of England and England (52.1% and 52.4% respectively). Data is not available regarding the South Asian community in Peterborough, however nationally a greater proportion of Asian/ Asian British (incl. Chinese) were meeting the recommendation compared to the population as a whole (60.3% and 52.4% respectively).

## Community Survey Result

The survey suggests that as few as 8% of those surveyed meet the recommended '5-a-day' recommendation for consumption of fruit and vegetables. Females are more likely to be consuming

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<sup>29</sup> Khunti et al (2009) Diabetes UK and South Asian Health Foundation recommendations on diabetes research priorities for British South Asians. Diabetes UK.

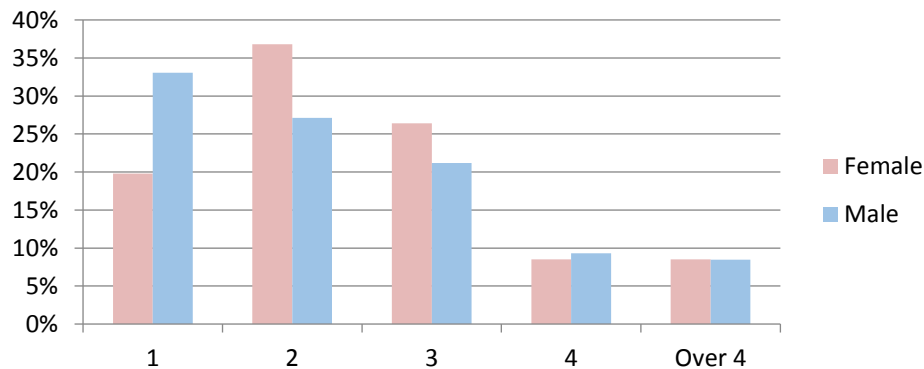
<sup>30</sup> Local action on health inequalities Understanding and reducing ethnic inequalities in health. PHE 2018

<sup>31</sup> <https://www.bhf.org.uk/information-support/heart-matters-magazine/medical/south-asian-background>

<sup>32</sup> What About YOUth (WAY) survey, 2014/15 <https://digital.nhs.uk/data-and-information/publications/statistical/health-and-wellbeing-of-15-year-olds-in-england/main-findings---2014>

more than two portions a day. See Fig 10. The survey also sought views on salt and sugar intake. 56% reported being mindful of their salt intake, whilst 59% reported being mindful of their sugar intake.

**Fig 10. In a typical day, how many portions of fruit and vegetables do you eat?**



### Focus Group Result

A number of problems exist in relation to maintaining a healthy diet. There is a lack of knowledge regarding the potential health risks associated with traditional cooking and how to adapt recipes to make them healthier. The 'Eat Well' guide may be more accessible than information regarding calories, as its uses commonly understood portion and measures e.g. teaspoons of sugar. Misconceptions may exist in relation to the affordability of healthy diets.

Ramadan is associated with a change in eating patterns which may result in overeating at night and an overall worsening of diet during this period. Cultural festivals are usually food and eating focused which reinforces a culture around food. However it may also present an opportunity for education.

### Smoking

According to the Annual Population Survey (2017), 17.6% of adults in Peterborough are current smokers. This is statistically similar to England as a whole (14.9%) but higher than the average for the East of England (14.2%). However in line with national and regional trends levels of smoking have been on a steady decline.

National data suggests levels of smoking in the Asian community (9.3%) are lower than the national average (14.9%). This data also shows that prevalence of smoking declines with age, being highest amongst 25-39yr olds (20.8%). For those over 65-69 years it is 11%, reducing to 1.5% of those aged 90 or over.

Smoking rates amongst South Asian men (16.5%) are 5 times that of women (3.3%). Amongst men, prevalence of smoking for those of Muslim faith is 21.3%, which is higher than men from all other faiths used in the survey<sup>33</sup>. The survey found 7.3% of Sikh faith and 12.3% of Hindu faith smoked.

The 2004 Health Survey for England reported that chewing tobacco was most common among people identifying as Bangladeshi (9% of men and 16% among women aged 18 and over), with much lower rates among men and women in the Indian and Pakistani groups.

### Community Survey Result

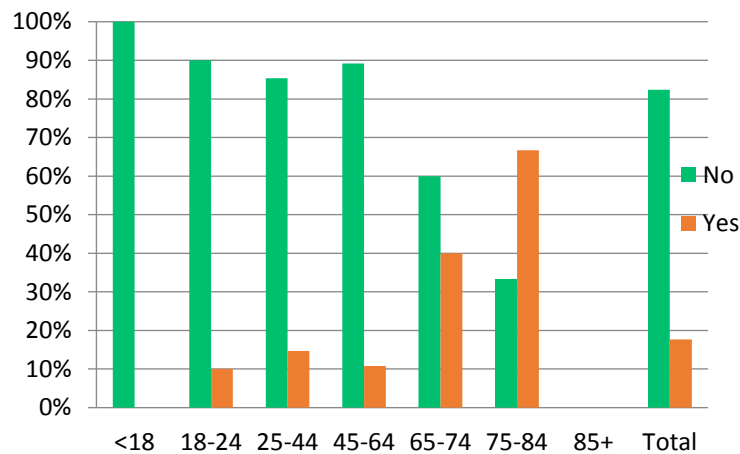
The local survey data found 11% of those under 65 reported smoking. The excludes 11% of respondents in that age group who didn't provide an answer. Data relating to those over 65yrs cannot be reported due to small number of responses

Overall 26% of men reported smoking. Very few women reported being a current smoker which suggests that the survey may not a reliable method for ascertaining smoking prevalence amongst women.

The proportion of those who smoke by age group is shown in Fig 11. This question was answered by 89% of respondents.

Anecdotal evidence from the healthy lifestyles provider in Peterborough, Solutions4Health suggests that smoking is more prevalent with young people (<25yrs) than the survey would suggest. They also report widespread popularity of shisha in this age group.

**Fig 11. Do you smoke?**



<sup>33</sup> Christian, Buddhist, Hindu, Jewish, Sikh, Other, None

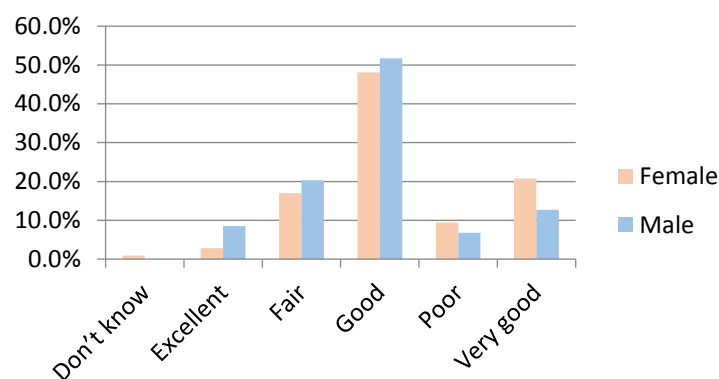
## Perceptions of Health and Seeking Help

### Community Survey Result

Participants were asked how they would rate their health, the conditions they have and what they worry about.

Overall, 72% of respondents felt their health was 'good', 'very good' or 'excellent'. 9% rated their health as poor. This was similar between men and women. A greater proportion of men rated their health as excellent compared to women (8.5% vs 2.8%). See Fig 12.

**Fig 12. Thinking about your own health: would you say that in general your health is;**

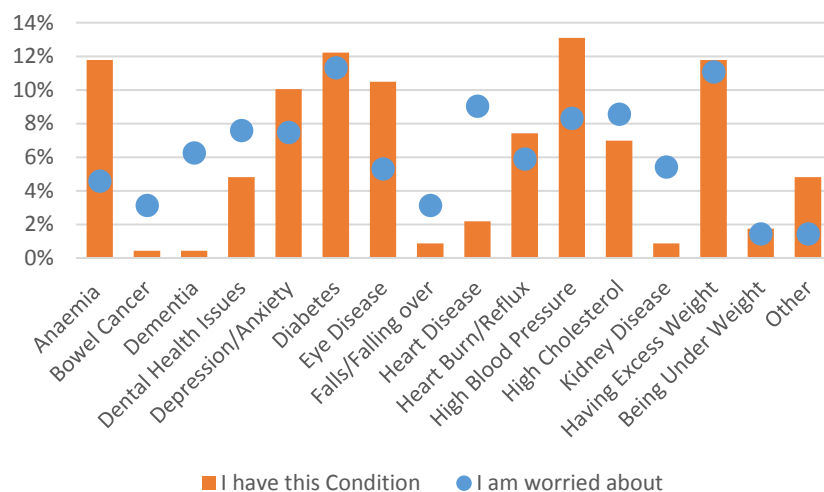


The top 5 most prevalent conditions amongst those surveyed were high blood pressure (13%), diabetes (12%), anaemia (12%), having excess weight (12%) and eye disease (10%).

The top 5 conditions that participants worried about were diabetes (11%) and having excess weight (11%). Heart disease (9%) High cholesterol (9%), high blood pressure (8%)

Depression and anxiety was also something that people experienced (10%) and worried about (8%).

**Fig 13. Please indicate what you are worried about:**

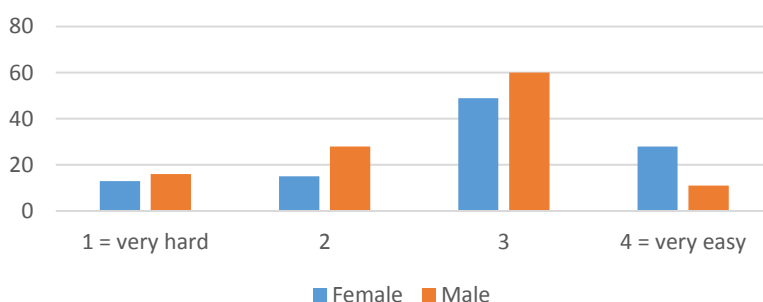


Survey participants were asked whether they had needed medical attention in the past 12 months. Less than half (49%) answered this question, of which two thirds had needed medical attention. The local GP was the place where the vast majority had sought help (97%). Nearly half (48%) had attended hospital (e.g. accident and emergency). A quarter had attended the Minor Illness and Injury Unit. Very few (2%) reported that they had wanted to seek medical attention but were unable to.

Unfortunately there was insufficient data to determine whether the need for medical attention varied by self-reported condition (e.g. depression/anxiety, high blood pressure).

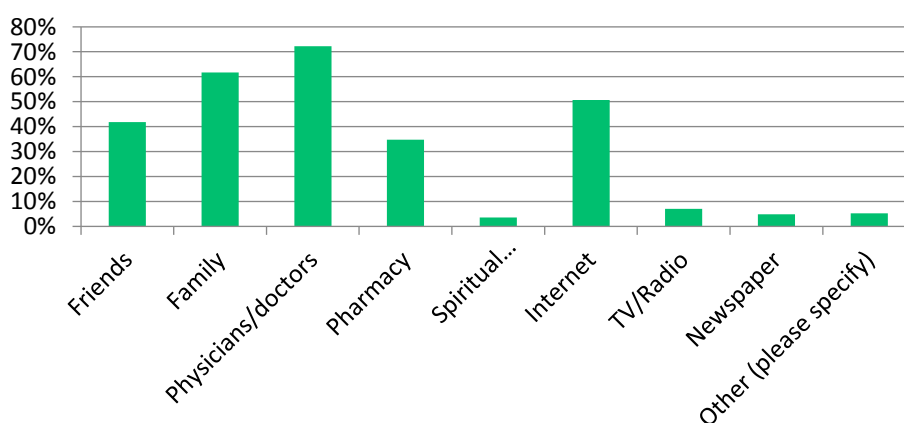
Fig 14 shows how people regard ease of access to health services. Men are more likely than women to report finding this hard.

**Fig 14. On a scale of 1-4, how easy is it to for you to access health services?**



Survey participants were asked where they get their health information from. See Fig 15. Physicians/doctors were the most common source of information, followed by family and friends. Approximately 50% of participants used the internet. A higher proportion if those aged under 44 use the internet as a source of information compared to older people. Sixty per cent of 18-24yr olds and 50% of 25-44yr olds use the internet, compared to 43% of 45-65yr olds.

**Fig 15. Where do you get health information from? (Select all that apply)**



### Focus Group Result

Some women may not access appointments or seek services in a timely fashion despite knowing that they have a problem/issue. This can be due to other pressures such as; family commitments and extended family pressures. They may have to seek permission to access services. Confidentiality may be comprised due to the involvement of spouses and the involvement of children who act as interpreters. The woman's mother-in-law may be required to come to the appointment with her sister in law. This all creates low motivation and barriers to attending services. These kind of issues and pressures can also lead to deteriorating mental health.

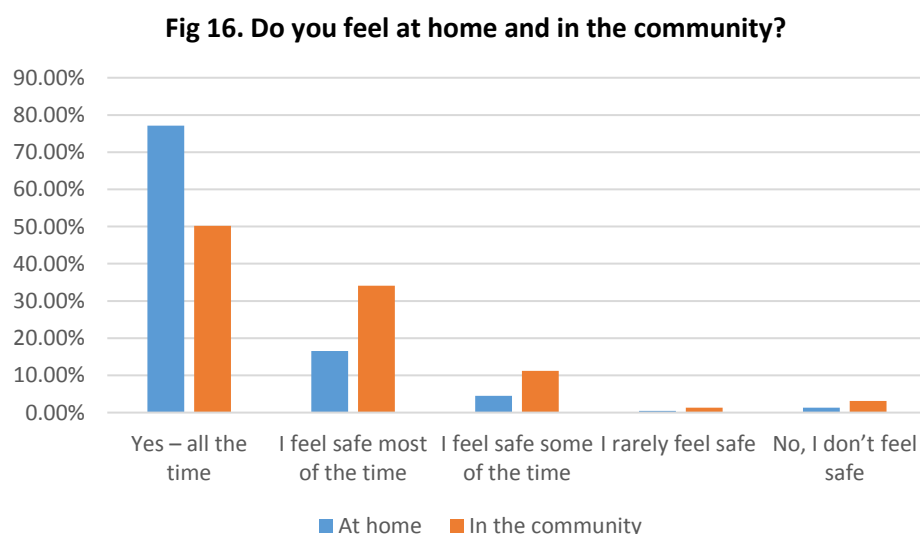
Language barriers are also an issue in understanding health related information and accessing services.

## Safety and Access to Community Services

### Community Survey Results

Access to community facilities can help support and improve health and wellbeing of those living in the area. For example, there is clear evidence that access to, and engagement with, the natural environment is associated with numerous positive health outcomes, including improved physical and mental health, and reduced risk of mortality and other conditions.<sup>34</sup> Community centres and libraries are often at the heart of local areas, and provide a place to meet, hold social, cultural and educational activities for all ages and a place for people to get involved in the community's life.

Perceptions of crime and feelings of safety are important factors contributing to mental health and well-being and influence our healthy behaviours such as physical activity and access to green spaces. Fig 16 shows that the vast majority of survey respondents feel safe at home or in the community most or all of the time. Of the 10 people over 65yrs who answered these questions, all but one indicated that they felt safe at home and in the community, all or most of the time. For those under 25 years old (n=13), none responded 'I rarely feeling safe' or 'no, I don't feel safe'.



<sup>34</sup> Spatial Planning for Health. An evidence resource for planning and designing healthier places. PHE 2017.

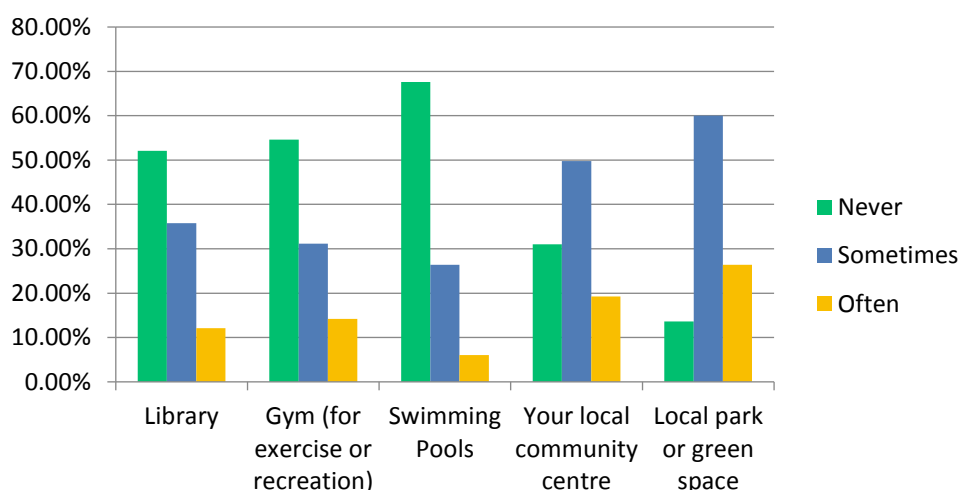


There is some survey evidence<sup>35</sup> that as much as 75% of the population in England visit a library 1-2 times/year or less, with 67% not visiting at all. Approximately 15% visit a library more than once a month. By comparison our survey shows that just over half never visit a library, 12% visit often and 36% sometimes visit.

The same survey reported that 12.4% of those surveyed had participated in swimming or diving. Our survey found that 26% sometimes visited the swimming pool and 6% did so often.

It is estimated that approximately 18% of Peterborough residents take a visit to the natural environment for health or exercise purposes in an average week<sup>36</sup>. This includes anywhere which is "out of doors" but doesn't include routine shopping trips or time spent in own garden. Our survey found that 26% of respondents used a park/green space often, although reasons are not specified.

**Fig 17. How often do you use the following?**



## Children and Education

### Introduction

Education is an important social determinant of health. A good education confers a number of benefits, including the building of supportive social connections, accessing good work, life-long learning and problem solving and feelings of empowerment and value<sup>37</sup>. School readiness is an important measure of how prepared a child is to succeed in school cognitively, socially and emotionally. Children without a good level of development at age 5 will struggle with social skills,

<sup>35</sup>Taking Part Survey (2015/16)

<https://public.tableau.com/profile/taking.part.survey#!/vizhome/WhoParticipates-HeritageMuseumsandGalleriesLibrariesArchives/Responsesbreakdowns>

<sup>36</sup> [https://fingertips.phe.org.uk/profile/comm-](https://fingertips.phe.org.uk/profile/comm-assets/data#page/6/gid/1000031/pat/6/par/E12000006/ati/102/are/E06000031/iid/11601/age/164/sex/4)

[assets/data#page/6/gid/1000031/pat/6/par/E12000006/ati/102/are/E06000031/iid/11601/age/164/sex/4](https://fingertips.phe.org.uk/profile/comm-assets/data#page/6/gid/1000031/pat/6/par/E12000006/ati/102/are/E06000031/iid/11601/age/164/sex/4)

<sup>37</sup> <https://www.health.org.uk/infographics/how-do-our-education-and-skills-influence-our-health>

reading, maths and physical skills. This will have an impact on their childhood and later life, such as educational achievements, involvement with crime, health and life expectancy<sup>3839</sup>. People with the lowest healthy life expectancy are 3 times more likely to have no qualifications compared to those with the highest life expectancy<sup>40</sup>.

### 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'.

Table 9 below presents a more detailed picture of the ethnic mix of children in state funded schools in Peterborough, compared with Cambridgeshire, East of England and England. In Peterborough, Asian pupils are the largest minority ethnic group accounting for 17% of primary and 18% of secondary school pupils. Within this group Pakistani children are the largest group, making up 11% of primary and 13% of secondary school pupils.

**Table 9. Ethnicity of primary and secondary school pupils, School Census January 2018.**

	White	White British	Mixed	White And Asian	Indian	Pakistani	Banglade shi	Any Other Asian Backarou	Black	Chinese	Any Other Ethnic Group	All pupils
<b>Primary Schools</b>												
<b>ENGLAND</b>	3,485,200	3,115,863	291,019	69,250	145,021	208,826	80,666	87,486	261,674	22,552	92,380	4,716,244
<b>EAST OF ENGLAND</b>	422,866	375,008	31,982	7,762	9,608	12,868	6,345	6,788	17,460	2,150	5,063	520,187
Cambridgeshire	44,620	38,323	2,945	900	688	336	367	765	630	421	515	51,803
Peterborough	14,468	10,040	1,282	341	564	2,374	43	572	751	79	266	20,796
<b>Secondary Schools</b>												
<b>ENGLAND</b>	2,416,841	2,222,444	170,140	40,322	98,749	142,011	59,244	60,018	189,653	12,930	58,650	3,258,451
<b>EAST OF ENGLAND</b>	305,698	280,727	19,000	4,677	6,505	8,573	4,367	5,081	13,311	1,562	2,857	373,639
Cambridgeshire	28,097	25,274	1,471	454	281	170	250	342	358	176	202	32,054
Peterborough	10,762	8,211	942	264	374	2,046	36	303	524	53	135	15,458

<sup>38</sup> Social Mobility Commission (2017) State of the Nation 2017: Social Mobility in Great Britain.

<sup>39</sup> Institute of Health Equity (2010) Fair society, healthy lives: The Marmot Review.

<sup>40</sup> An overview of lifestyles and wider characteristics linked to Healthy Life Expectancy in England: June 2017. Office for National Statistics.

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/articles/healthrelatedlifestylesandwidercharacteristicsofpeoplelivinginareaswiththehighestorlowesthealthylife/june2017>

## 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%).

**Table 10 – 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%

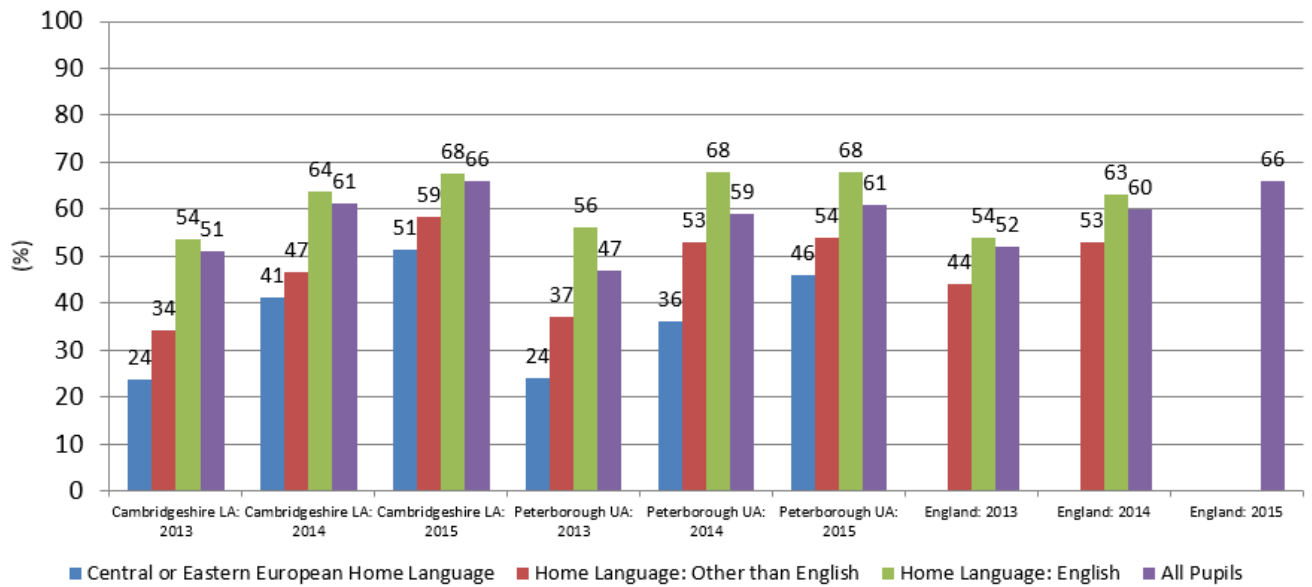
Source: School census data 2015

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.

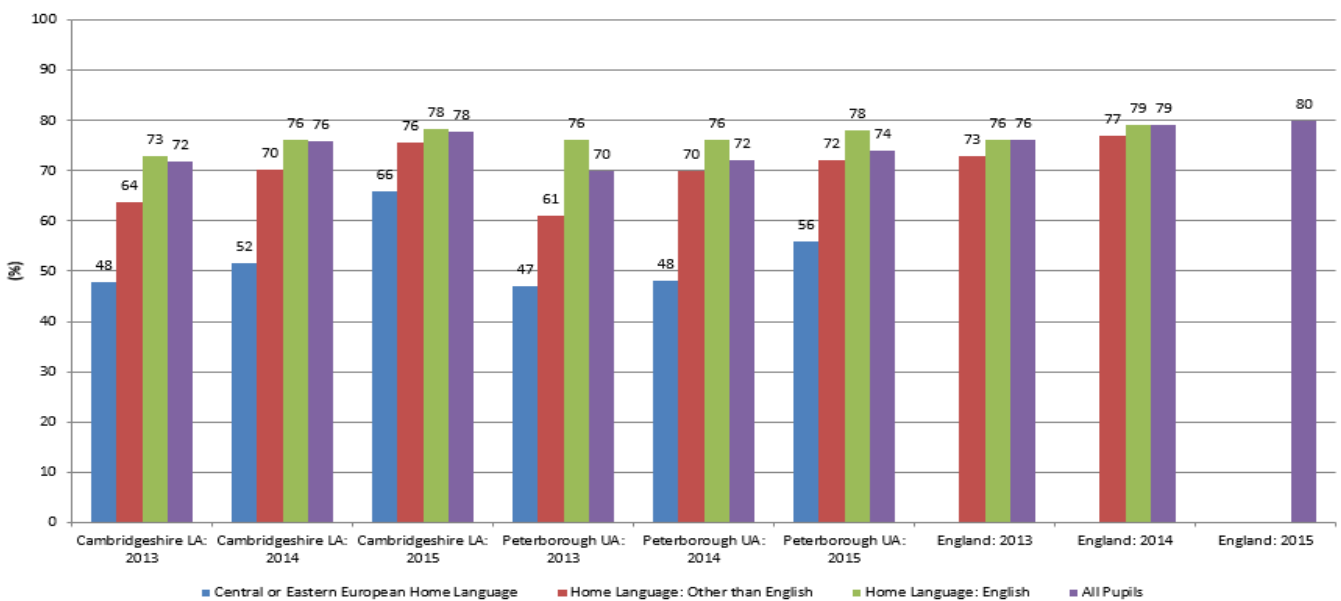
**Fig 18. Proportion of Pupils Achieving a Good Level of Development in the Early Years Foundation Stage Profile by Primary Language Spoken at Home , 2013-15**



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.

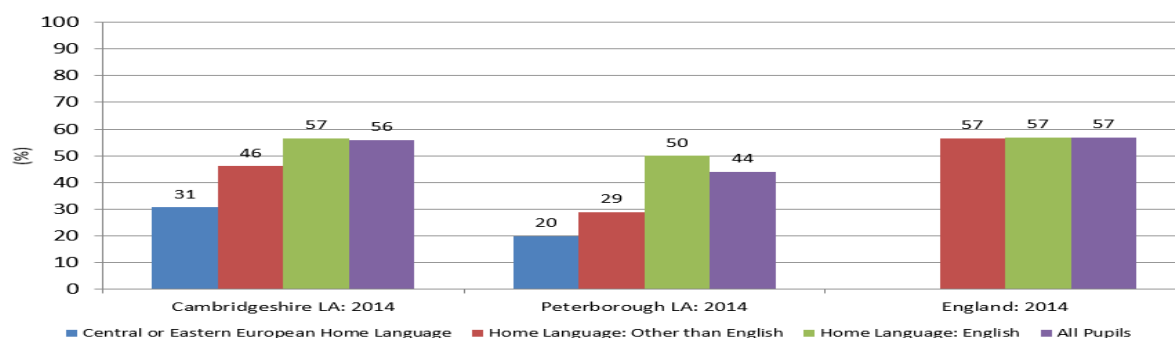
**Figure 19. Proportion of Pupils Achieving L4+ in Key Stage 2 Reading, Writing TA & Mathematics, 2013-15**



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 20: 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.<sup>41</sup>

**Table 11. : 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%

<sup>41</sup>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/419595/Working\\_Together\\_to\\_Safeguard\\_Children.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf)

Table 11 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.

## Income, Employment and Poverty

There is a strong evidence to suggest that work is generally good for physical and mental health and wellbeing, taking into account the nature and quality of work and its social context, and that worklessness is associated with poorer physical and mental health.

Likewise, low incomes and poverty are important determinants of health, the impacts of which are numerous and far reaching. For example, poor access to good quality housing (which is safe, secure, free from damp, not overcrowded).

### Employment

In Peterborough during 2017/2018, 23% of the population aged 16-64yrs were economically inactive. This means they are either not in employment or unemployed. There are many reasons for this including studying, looking after family or long-term sickness. However, national surveys suggest that approximately 38% of men and 24% of women would like a job<sup>42</sup>

<b>Table 12. Proportion of economically inactive residents of Peterborough aged 16-64, 2017/18</b>		
<b>Ethnic Group</b>	<b>%</b>	<b>CI</b>
White	21%	5%
Indians	32%	*
Pakistanis/Bangladeshi	50%	25%
Black or Black British	!	!
All ethnic minorities	33%	13%
<b>Males</b>		
White	18%	7%
Indian	!	!
Pakistani/Bangladeshi	18%	*
Black or Black British	!	!
All ethnic minorities	18%	*
<b>Females</b>		

<sup>42</sup> Annual Population Survey. [www.nomisweb.co.uk](http://www.nomisweb.co.uk)

White	24%	7%
Indian	44%	*
Pakistani/Bangladeshi	78%	28%
Black or Black British	!	!
All ethnic minorities	44%	18%
! Estimate and confidence interval not available since the group sample size is zero or disclosive (0-2)		
* Estimate and confidence interval unreliable since the group sample size is small (3-9).		

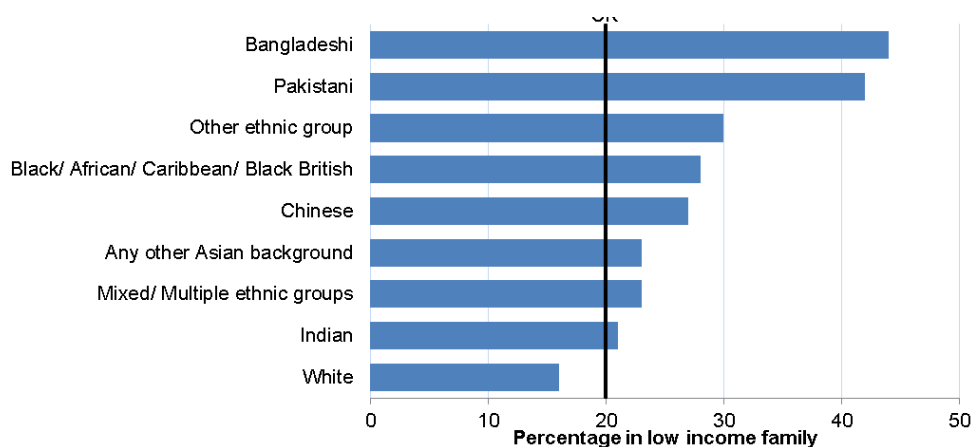
Table 12 shows that there is a significant disparity between the Pakistani/Bangladeshi community and other ethnic groups in terms of those who are economically inactive. This is even more marked for the community of Pakistani women, of which nearly 80% are inactive. This is double the proportion of all women from all ethnic minority groups.

## Income

Data from the Department of Work and Pensions shows that 16% of the UK population lives on a low income (defined as below 60% of the median national income). However, this varies by ethnic group. Thirty five per cent of people living in households headed by someone of Pakistani or Bangladeshi ethnic origin are living on a low income compared to 14% of the White population. The proportion on a low income is even higher after housing costs are taken into account, rising to about half of the Pakistani, Bangladeshi and Chinese populations affected<sup>43</sup>.

Child poverty is an important issue for public health. The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Nationally, wide inequalities exist by ethnic group, with the highest proportion of children living in low income families in the Bangladeshi and Pakistani ethnic groups. See Fig 21.

**Fig 21. Proportion of children living within low income families. United Kingdom, 2015/16**



<sup>43</sup> Department for Work and Pensions. Households below average income statistics: 1994/95 to 2016/17. DWP March 2018. [online] Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/691917/households-below-average-income-1994-1995-2016-2017.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691917/households-below-average-income-1994-1995-2016-2017.pdf)

## Summary

The South Asian Communities in Peterborough face some significant public health challenges. The levels of obesity and its consequences for health (such as diabetes and cardiovascular disease) are known to be higher amongst the South Asian communities. Our local survey data supports national data suggesting physical activity levels are lower and diets are poorer in South Asian communities. By the age 11 years, a far higher proportion of children from South Asian communities are overweight compared to their peers. The survey found that the top 5 things people worry about were all related to excess weight, including, diabetes, high blood pressure, high cholesterol and heart disease.

Nearly three quarters of respondents to the local survey reported their health as 'good', 'very good' or 'excellent'. Whilst this is encouraging, there is a potential for complacency. The mismatch between respondents who are overweight (65%) and think they are (12%) may indicate that there is a need for targeted work to educate the community about healthy weight and the negative consequences of overweight.

The health needs assessment also highlighted a number of additional issues in relation to the health of women's in South Asian communities which would benefit from further exploration and co-ordinated action. For example; nationally, levels of breast and cervical screening are lower compared to the national average; the prevalence of common mental disorders are higher than for white British women; South Asian women are far less likely to be economically active than white British women; South Asian women face significant cultural barriers in accessing help and advice for health concerns.

The community also faces some wider challenges in relation to child poverty and employment, both of which have an impact on health. In particular, far fewer women are economically active than the white or BME population as a whole. Pakistani or Bangladeshi children are more likely to be living in low income households than other ethnic groups.

The needs assessment also identified some positive findings. The prevalence of tuberculosis has been on a steady decline. Generally, smoking levels are lower than the general population and overall, the South Asian population have a lower incidence of cancer than the white population. The vast majority of the survey respondents reported feeling safe at home and in their communities and very few report problems in seeking medical help or advice.

It should be noted however that many of the health challenges highlighted above are also present for other ethnic groups and for the population as a whole. It is clear however that when considering the recommendations presented by this report, consideration of the cultural context and working closely with the communities concerned will be key.



## Recommendations

1. Consider undertaking an equity impact assessment or similar to explore the uptake of screening amongst the South Asian communities.
2. Convene an expert group to explore need and options for targeted messaging around screening and organ donation to increase uptake.
3. Undertake a series of focus groups and workshops to consider how to improve access or support for mental health, working with colleagues from the provider mental health trust, Sustainability and Transformation Partnership and other stakeholders.
4. Work with the Joint Mosque Council and other community leaders to develop a public health awareness campaign focussed on diet, physical activity and their benefits for health.
5. Consider the development of a South Asian Women's Health Forum to explore and address the issues raised in the report.
6. Ensure that the current development of an early years (0-5) strategy takes into consideration the needs of the South Asian communities.

## Appendix 1 – Survey Questionnaire

Gender

Age band (0-17, 18-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75+)

Primary language

Highest level of education

Country of birth

Length of living in UK

Income

Employment status

Faith group

Household members (number)

Bedrooms

Thinking about your own health: would you say that in general your health is.. (poor....excellent)

Please indicate whether you are worried about or affected by any of the below the condition(s)

How often do you exercise for at least 30 minutes? (Note: exercise is counted as any movement equivalent to or above that of a brisk walk)

Do you smoke?

How often do have takeaway food/meals? (fast foods)

In a typical day, how many portions of fruit and vegetables do you eat?

Are you mindful of your sugar intake?

In the past 12 months, have you needed medical attention?

Where did you seek medical care? (Select All that apply) (e.g. GP, walk-in centre, A&E)

On a scale of 1-4, how easy is it to for you to access health services?

Where do you get health information from? (Select all that apply) (e.g. internet, family, GP, TV)

How often is someone available to help with daily chores if you are sick?

How often are family/friends available to meet with you socially for fun?

How often do you use the following? (library, parks, gym, swimming pool)

Do you feel safe at home?

Do you feel safe in the community?