HEALTH NEWS BRIEFING

ASSOCIATION OF COMMUNITY HEALTH
COUNCILS FOR ENGLAND AND WALES

CHCs and Black and Ethnic Minorities

May 1998

SUMMARY

Established in 1974 to represent patients and give them a voice in the NHS, Community Health Councils (CHCs) are sometimes perceived as being white middle class organisations, unable to articulate the needs and concerns of the black and ethnic minority communities within their area.

The Association of Community Health Councils for England and Wales (ACHCEW) is aware of this criticism of CHCs and has been taking an active interest in the health needs of people from black and ethnic minority communities.

This Health News Briefing looks at the involvement of CHCs with black and ethnic minority health issues and examines the results of an ACHCEW survey that was initiated following work done by the Greater London Association of Community Health Councils.

The Briefing concludes that some CHCs are involved in imaginative and interesting projects. Reports produced by CHCs show that they are increasingly aware of and involved with the black and ethnic minority communities in their area.

The survey identifies that CHCs in areas with larger black and ethnic minority communities tend to be ones most aware of and involved with these communities. However there are some CHCs that could be doing more.

In areas with small black and ethnic minority populations there is a real danger that these communities can be forgotten or ignored: yet their health needs still need to be reflected in service provision.

It is hoped that this report will stimulate discussion and help CHCs examine the way they address black and ethnic minority health.

CONTENTS

1. Introduction

Community Health Councils (CHCs) were established in 1974 to represent the interests in the health service of the public in its district.

However "the community" CHCs serve often includes diverse groups of communities. Within each district one will often find areas of relative affluence in close proximity to deprived areas with high levels of unemployment and poverty.

Black and ethnic minority groups often make up smaller communities within the wider community. These groups can have particular health or cultural needs that are not always recognised by the health service. CHCs have a vital role in helping to identify these needs and engage with black and ethnic minority communities, health authorities and Trusts to help improve the service that the NHS provides.

Indeed just how important the CHC's role is in representing black and ethnic minority groups is illustrated by the admission by the Department of Health that involvement of these groups by purchasers of health care "*was found to be limited across the whole population where the mechanism used was traditional and formal, for example, through consultation through Community Health Councils.*"[1]

However the degree to which CHCs successfully represent the views and health needs of black and ethnic minority groups has been subject to some debate. Back in 1990 the Association of Community Health Councils for England and Wales (ACHCEW) organised a conference "Working Towards Health For All: CHCs, the NHS and our Multi-Cultural Community" . The report of that conference stated that "*both the NHS and CHCs have a long way to go before the needs of the multi-cultural community will be met with any degree of adequacy*" [2]

Four years later the Greater London Association of Community Health Councils (GLACHC) reported that "*On the whole there is a wide range in the level of awareness and involvement of CHCs in race and health issues. There are some isolated examples of good CHC initiatives. These are patchy, however, and sometimes not followed through when key officers or members move on. In some cases CHCs follow the lead of other bodies such as local authorities or the DHA, rather than being in the forefront of setting the local agenda on race and health issues.*" [3]

The King's Fund is also critical of CHCs' involvement in black and ethnic minority health issues, arguing that they "*have developed primarily as white middle class bodies. They rarely have race issues on their agenda, nor have black communities any great expectations of them as their potential advocates. Their statutory right to consultation has also tended to dominate their work programmes, trapping them in the bureaucracy of formal responses*".[4]

However the King's Fund is not dismissive of the potential of CHCs to become advocates of black and ethnic minority communities citing the example of Sandwell CHC. Here the CHC in conjunction with the local health authority was involved in supporting the work of projects dealing with black elders with strokes and a mental health advocacy service. The King's Fund found that following the CHC's involvement "*Black users and voluntary organisations have become clearer about its role in monitoring and improving health services through representing users. The Project's exit strategy includes a funding proposal to the health authority for future development work to be carried out through the CHC. This combines the traditional monitoring function of the CHC with the need to ensure that the project findings are followed through.*"

In latter half of 1996 ACHCEW carried out a survey of its member CHCs (then 206 out of a possible 207) in an attempt to gauge CHC involvement with black and ethnic minority communities. This work follows on from that conducted by GLACHC - taking forward some of the issues raised in "From Here to Equality".

ACHCEW's survey found some CHCs involved with black and ethnic minority groups in a variety of innovative and interesting ways, demonstrating the diversity of both the CHCs and the communities that they represent. However, it found other CHCs somewhat less involved.

This report does not attempt to establish the health inequalities between black and ethnic minority communities and white communities. The statistics and debates surrounding this issues are well documented elsewhere[5 6]. This report is also not intended as a definitive statement of this CHC activity, but as a document designed to help CHCs examine the way they are involved with their local black and ethnic minority communities.

Its aim is to identify the level of CHC involvement in black and ethnic minority health issues based upon the survey ACHCEW carried out in 1996 and to examine some of the innovative projects that CHCs are undertaking. It is hoped that it will stimulate discussion in CHCs and help disseminate examples of good practice.

A note on terminology:

Ethnicity is a multi-dimensional concept. This report does not examine the debate surrounding ethnicity and ethnic identity. To do so would be outside its main purpose. The use of the terms "black and ethnic minority groups" and "black and ethnic minority communities" are employed in their broadest sense.

2. ACHCEW's Survey

In 1996 GLACHC produced what they described as a checklist[7] for CHCs which aims "*to highlight the practical issues for CHCs in implementing the recommendations outlined in From Here To Equality*" - the document GLACHC produced looking at CHCs involvement with black and ethnic minority groups. (See Appendix A).

In September 1996 ACHCEW surveyed its member CHCs about their involvement in black and ethnic minority health issues. Of the then 206 members, 192 replied - a 93% response rate. The survey was designed to ascertain the level of CHC involvement in black and ethnic minority issues.

The ACHCEW survey picked up on a number of the issues highlighted in this checklist to ascertain whether CHCs in England and Wales had in place structures to improve their links with black and ethnic minority communities. Whilst the GLACHC checklist is far more extensive it was felt that the ACHCEW survey, examining just some of the issues raised, would provide a snap shot of CHC activity and awareness.

The questionnaire asked five questions:

Q1. Does your CHC have formal or informal links with local black and minority ethnic groups?

Q2. Do local black and minority ethnic voluntary organisations nominate people to be members of the CHC?

Q3. Does the CHC have a Race and Health Working Group?

Q4. Does the CHC have a policy about asking specific questions about services for black and minority ethnic people when visiting hospital and other health services?

Q5. Has your CHC initiated or been involved in any local projects/research which target black and minority ethnic health needs? (e.g. research into health needs, advocacy work).

The responses were analysed and CHCs grouped first by geographical type. The three categories are urban, rural and "mixed" - to cover those CHCs that have areas of built up conurbation as well as rural areas.

The CHCs were then divided up into their NHS regions and Wales to establish whether there are any significant regional variations in CHC involvement with black and ethnic minority groups.

Breakdown of the results

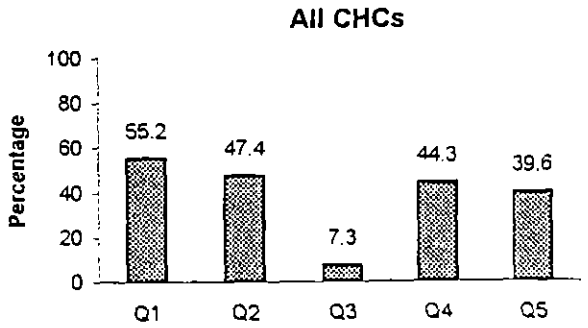
2.1 By "geographical" type:

All CHCs

This includes all CHCs that were a member of ACHCEW at the time of the survey (206 CHCs out of a possible 207).

Total number in this group: 206.
Number that responded: 192
Response rate: 93%

Just over half of all CHCs have formal or informal links with local black and ethnic minority groups. However less than one in ten CHCs have a Race and Health Working Group to look at specific black and ethnic minority group health issues.

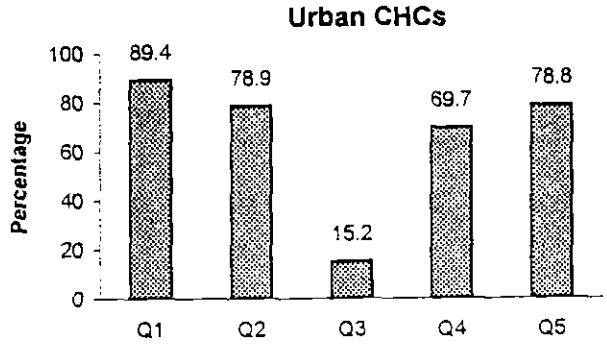


Urban CHCs

Total number in this group: 71.
Number that responded: 66.
Response rate: 93%

There was a higher level of involvement with black and ethnic minority groups (as arguably one would expect) with almost nine out of ten urban CHCs having formal or informal contact.

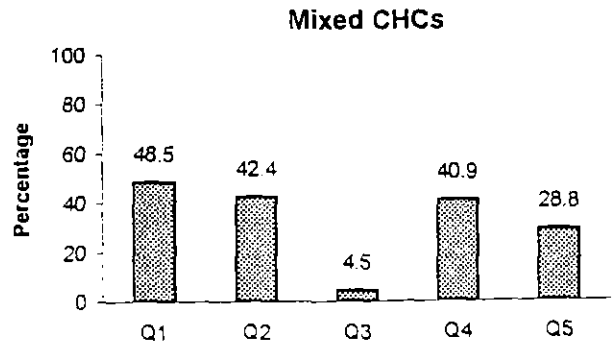
Urban CHCs gave a positive answer to all five questions at approximately double the total CHC rate.



Mixed CHCs

Total number in this group: 73.
Number that responded: 67.
Response rate: 92%

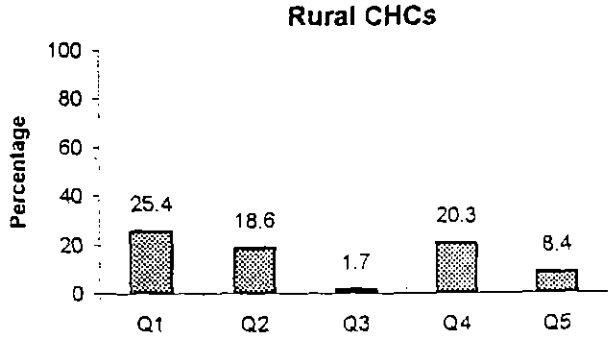
The survey returns showed "mixed" CHCs' involvement with black and ethnic minority groups is a little lower than that of all CHCs. As is the trend with all categories there are only a small number of CHCs from mixed areas that have a Race and Health Working Group.



Rural CHCs

Total number in this group: 62.
Number that responded: 59.
Response rate: 95%

Rural CHCs are significantly less likely to be involved in black and ethnic minority health issues than either urban or "mixed" CHCs with only one in four having formal or informal links with black and ethnic minority groups.



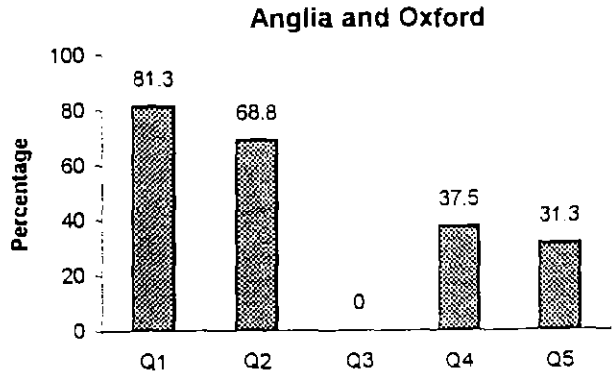
2.2 England: by region

Data was broken down by region to ascertain whether there were any regional variations in CHC involvement in black and ethnic minority health issues.

Anglia and Oxford

Total number in this group: 17.
Number that responded: 16.
Response rate: 94%

The most significant finding in Anglia and Oxford is that the CHCs have a high level of formal and informal links with local black and ethnic minority groups. Although interestingly they have no Race and Health Working Groups.

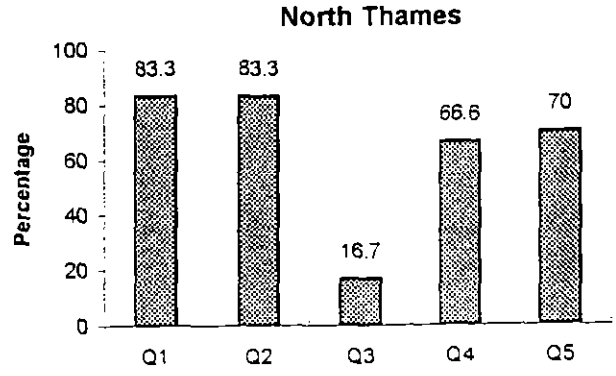


North Thames

Total number in this group: 28.
Number that responded: 28.
Response rate: 100%

North Thames was the region that the survey showed to have the highest level of involvement in black and ethnic minority issues. In each question the Region scored the highest level of positive answers.

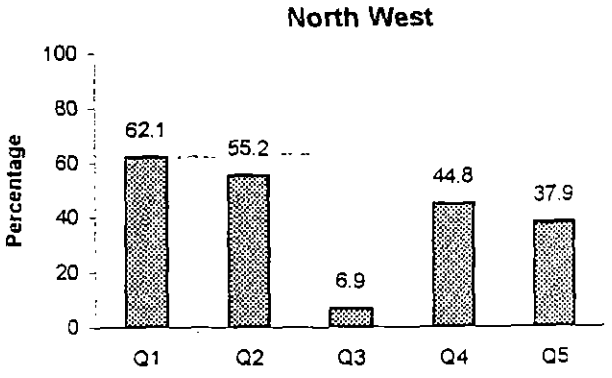
Particularly noticeable was that the number of CHCs involved in research targeting black and ethnic minority groups was over double the average for England and Wales.



North West

Total number in this group: 30.
Number that responded: 29.
Response rate: 97%

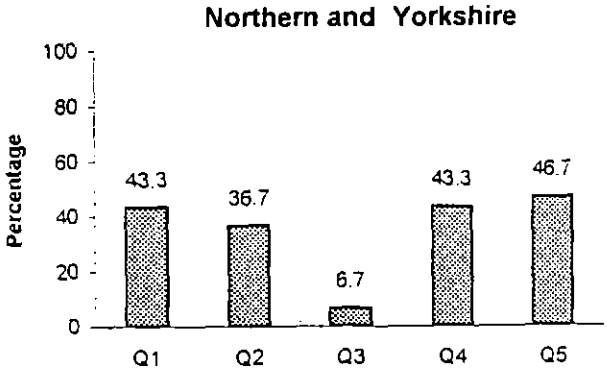
The survey showed the North West involvement in black and ethnic minority issues to be close to the average for England and Wales in each category.



Northern and Yorkshire

Total number in this group: 30.
Number that responded: 30.
Response rate: 100%

The survey found Northern and Yorkshire a little below average in the first four categories. However the Region scored above the average for England and Wales when it came to conducting local projects and research that targets black and ethnic minority needs.



South Thames

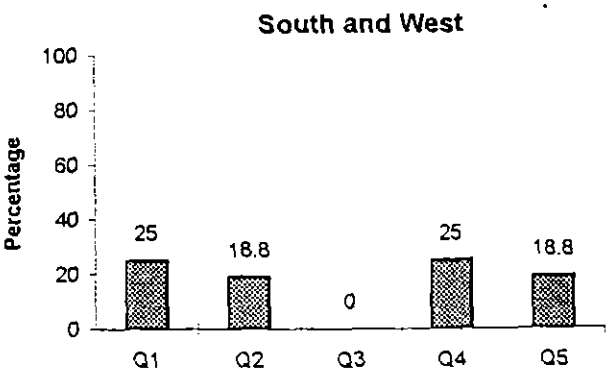
Total number in this group: 28.
Number that responded: 22.
Response rate: 79%

The survey found South Thames to be below the average for all categories except for the fourth; i.e. whether the CHC has a policy about asking questions about services for black and ethnic minority groups when visiting hospitals and other health services.

South and West

Total number in this group: 19.
Number that responded: 16.
Response rate: 84%

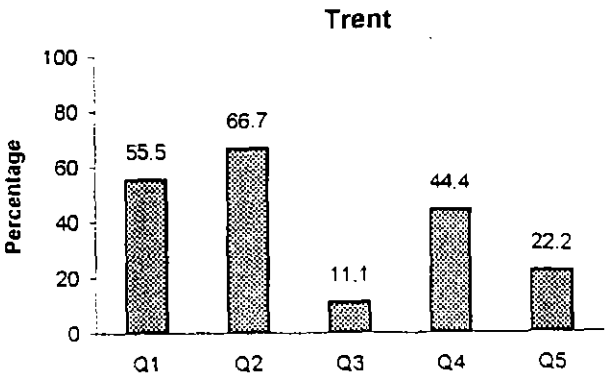
The survey found the South and West to score the lowest of any of the English Regions in their involvement in black and ethnic minority issues. Only one CHC in four had formal or informal links with black and ethnic minority groups and no CHC in the region had a Race and Health Working Group.



Trent

Total number in this group: 12.
Number that responded: 9.
Response rate: 75%

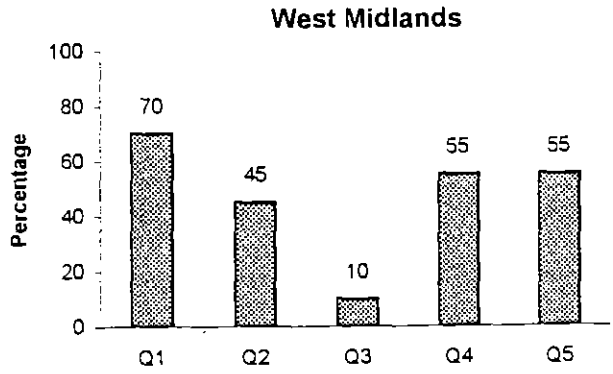
The survey found the Trent Region to either be about the average for England and Wales or just above average, except for category five (i.e. whether the CHC has been involved in local projects\research which targeted black and ethnic minority health needs) where the region was below average.



West Midlands

Total number in this group: 20.
Number that responded: 20.
Response rate: 100%

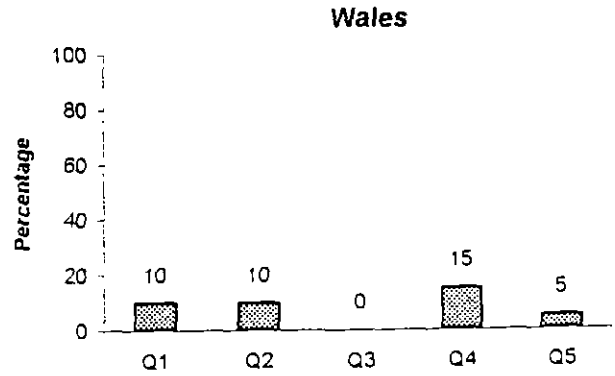
The survey found the West Midlands region to be above the average for England and Wales for all aspects of involvement in black and ethnic minority health issues.



2.3 Wales

Total number in this group: 22.
Number that responded: 20.
Response rate: 91%

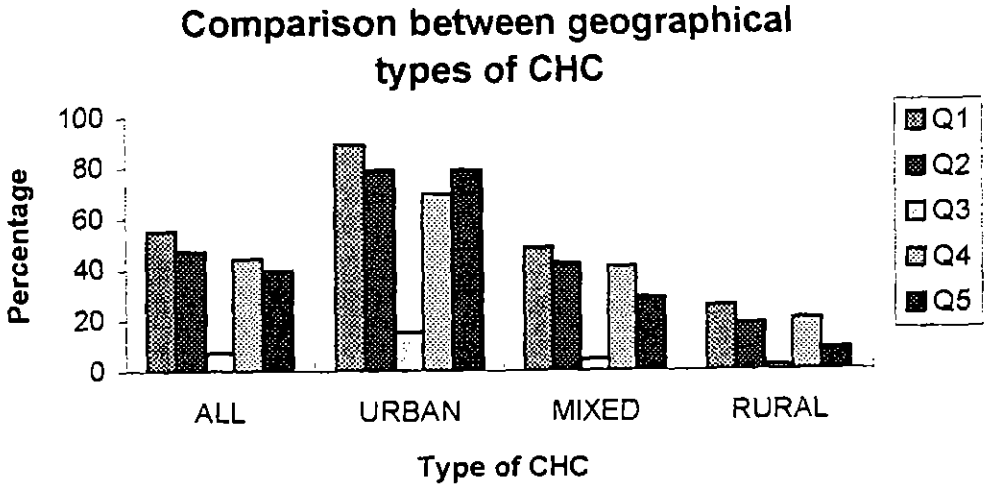
No CHC had a Race and Health Working Group and only one CHC was conducting local projects/research which targeted black and minority ethnic health needs.



3. The results of the Survey: what do they tell us.

The survey was intended to be a snap-shot of CHC involvement in black and ethnic minority health issues. However it cannot be seen as a definitive statement of the level of involvement.

The graph below shows the number of CHCs that answered yes to each of the questions. There is a clear pattern of urban CHCs demonstrating a higher level of involvement with black and ethnic minority issues. This could be explained by the greater concentration of black and ethnic minority groups in these areas (Appendix gives Department of Health figures for the percentage of black and ethnic minority people in each health authority). However as we will see later in this report some CHCs are particularly concerned with black and ethnic minority issues despite the small number of these communities within their area.



It was encouraging to see just over half of all CHCs have formal or informal links with local black and ethnic minority groups. However less encouraging was that less than one in ten CHCs have a Race and Health Working Group to look at specific black and ethnic minority group health issues.

The survey shows North Thames to have the highest CHC involvement in black and ethnic minority health issues and the South and West the lowest. However with the large concentration of black and ethnic minority communities in Greater London this is not surprising. Indeed when one compares the figures for the number of black and

ethnic minority people in each health authority (see Appendix) then a pattern can be observed. Of the ten health authorities with the greatest percentage of black and ethnic minority residents, seven are in the North Thames Region. Of the ten health authorities with the lowest percentage of black and ethnic minority residents, five are in the South and West Region.

It would appear that the greater the number of residents from black and ethnic minority communities then the greater the chance of the CHC being involved with those communities.

Wales was well below the average in all types of involvement when compared to the English regions. However with considerable smaller resources (both in the number of staff and financial) it would be unfair to draw any further comparisons.

4. Black and ethnic minority communities and CHC projects.

Some CHCs have a Black and Ethnic Minority Working Group (although they may have a different name) that meets regularly to discuss black and ethnic minority health issues.

Some CHCs are able to employ an Outreach Worker or Development Officer whose role is to engage black and ethnic minority communities with the CHC and with the local health authority and health providers.

CHC publications and project work on the ACHCEW databases identifies the different ways that CHCs can have a positive impact on the provision of health care for black and ethnic minority groups. These can be grouped into the following categories:

a) Identification of the different black and ethnic minority communities and their health needs/experience of health care provision.

b) Monitoring health care provision for black and ethnic minority communities.

c) Increasing shared knowledge of black and ethnic minority health issues by organising conferences and health forums.

d) Dissemination of health information to black and ethnic minority groups (production of leaflets, audio and video tapes in languages other than English; presentations and seminars aimed at specific black and ethnic minority groups; outreach work)

a. Identification of the different black and ethnic minority communities and their health needs / experience of health care provision.

Some CHCs have produced reports that profile black and ethnic minority groups in their area.

Salford CHC worked in collaboration with their local health authority and family health services authority in 1993 to produce a "Profile of Black Communities in Salford"[8]. The report outlines each community; giving each its population and locality; and such information as literacy rates, employment rates and how to engage with the community.

The report "*gives a profile of demographic and other characteristics of black communities in Salford....based on answers to questions drawn up by project team members....asked of representatives of local communities and of professionals who have contact with communities.*"

The report also contrasts its findings with those of the 1991 census and lists GPs in the area who speak relevant languages. Whilst it is now some what dated it is still in demand and considered the most informative publication of this nature available in Salford.

Wakefield CHC was involved in a joint project with Wakefield Health Authority as a result of a successful bid to the NHS Ethnic Health Unit for funding to undertake a research project to identify the barriers experienced by ethnic minority women in accessing primary and secondary health care services.

Black and ethnic minority communities in the Wakefield area are quite small when compared to the larger communities in neighbouring Leeds, Bradford and Kirklees. But for this reason Wakefield CHC felt it particularly important to examine this issue as they felt that isolated Wakefield communities were not accessing services available to them.

Research was carried out in four stages;

1. demographic profile of the ethnic minority community
2. the service map of existing resources for ethnic minority women
3. semi-structured interviews with health professionals and ethnic minority women
4. focus group discussions of key issues from research

The report[9] reaches a number of conclusions and reaches a series of recommendations about the way that services should be purchased, provided and monitored.

The report concludes that "*interpretation is the key to ethnic minority women effectively accessing healthcare services.*" It finds that ethnic minority women want to increase their knowledge of the health service but are unsure where to access this information and that cultural needs often pose additional barriers to accessing services. Recommendations include increasing the availability of interpreters; increased information accessible to ethnic minority communities; the need for outreach mechanisms; and the need for providers to explicitly state how they intend to address ethnic minority concerns.

Bristol and District CHC also examined the issue of black and ethnic minority women's health in their "Listening to Local Voices - Locality Purchasing Project." This project involves groups where "*the Purchaser was interested in hearing the views of local people or, where there were clear opportunities to build a partnership between local people and primary healthcare teams to develop local health services.*" [10]

The CHC deliberately chose to work with existing community groups as these groups are "*some of the most accessible ways of hearing the views similar to those of the 'person in the street'. It is less time consuming than trying to set up and support new groups, and it minimises the dangers of raised expectations because pre-existing*

groups are not dependent upon the outcome of local voices work for their continued existence".

Bristol and District CHC's finding were not unlike those of the Wakefield report above. Interpreting and translating services were seen as important as well as developing information, empowerment and support for Asian women.

b. Monitoring health care provision.

Between 1994 and 1996 **West Birmingham CHC** conducted a substantial study of hospital inpatient services for ethnic minorities[11]. The purpose of the project was to monitor the quality of acute service provision for ethnic minority patients within three acute hospitals within the city. The report stated that the main areas of investigation were:

"a) perceptions and experience of patients during their hospital stay
b) perceptions of nurses and working practices of nursing staff
c) perception of ward managers and working practices of management services
d) Patient's Charter standards
e) the physical environment of the hospital
f) information available for nurses and patients about the role of CHCs
g) outstanding policy issues which had not been addressed by the management"

Information was collected by interviewing 104 patients, 213 nursing staff; and conducting a written questionnaire with 46 ward managers. The report has a considerable number of findings.

Communicating with patients in their first language posed many problems with family and friends frequently being used as interpreters. This clearly is not always acceptable and prejudices confidentiality. Signs, leaflets and the hospital radio stations were almost always in English or where they had been translated they were often out of date.

Food was another issue that this report highlighted. This would appear to be of particular concern to patients from South Asian backgrounds since it found it to be a regular occurrence that relatives felt the need to bring in food for patients.

The report also found a need for greater training for staff in black and ethnic minority cultural traditions - particularly regarding how to deal with a death as required by the deceased religion.

The West Birmingham CHC report is detailed and lengthy, proving the CHC's ability to conduct research of considerable complexity and to highlight shortcomings in service

provision. Furthermore the CHC went on to produce a list of suggested service developments to improve services to patients[12] . These can be summarised as:

- Leaflets should be produced in minority languages about the key aspects of hospital life.
- Interpreters should be speedily available to all hospital wards and departments at all times.
- Patients' preferences for the type of food required should be obtained shortly after admission.
- Accommodation and facilities should be made culturally as sensitive as possible.
- Training for staff is needed for them to properly serve people from black and ethnic minorities.

In preparing "Better Health for Women and Children"[13] **Greenwich CHC** interviewed one hundred and eighteen women from all the major ethnic groups in the borough between March and June 1994. They also were involved in case studies and focus groups.

The report identifies six recommendations to improve service delivery. These can be summarised as:

- Commissioners, providers and GPs working with local ethnic communities as well as social services to set up an interpreting and advocacy service for primary care.
- Health authority and community providers to provide information on services available and how to get them.
- Health promotion to launch campaigns on when and how to use services.
- The Health authority should support GPs with information, training and resources.
- Primary care providers should ensure that services are appropriate, sensitive and accessible to all users.
- Commissioners, providers and social services to look into and begin to meet the health needs of particularly vulnerable sections of the population.

These recommendations clearly identify which groups of providers need to respond to improve services. The report also recommends that the CHC needs to:

> *"Work to increase awareness about the Community Health Council and its role amongst black and minority ethnic populations by*

- *Distributing leaflets on the CHC and its services in local languages*
- *Holding regular advice sessions in the venues used by black and ethnic groups"*

c. Organising conferences and health forums.

Some CHCs have successfully organised conferences on specific health issues of interest and concern to black and ethnic minority communities.

In 1995 **Lewisham CHC** organised a conference on Male Circumcision, with participants drawn from a wide range of interested local parties. In introducing the Conference Miriam Iloghalu, Chair of Lewisham CHC's Equality Issues Working Group described South East London as having a "*significantly large population which includes groups for whom male circumcision is a social, religious and cultural necessity.*"[14] The Conference explored the issue of male circumcision and whether it should be available on the NHS.

Hammersmith CHC also have experience of organising conferences. In 1997 they organised a conference entitled "Black, Visible and Mad?" following the growing concern from members of the CHC's Equal Opportunities (Race and Health) Working Group regarding the lack of policy and positive action to meet the needs of black and ethnic minority users of mental health services and their carers.

The Conference Chair, Mandana Hendessi, described the day as "*an occasion for us to exchange experiences and to start networking - an occasion to strengthen our campaigns, publicising widely the issues facing black and ethnic minority users of mental health services, and to start to work towards improving these services to meet their needs. It is imperative that the voice of black and ethnic minority mental health users is heard at every level of policy and service provision.*"[15]

The Conference involved guest speakers and participatory workshops which made a number of recommendations which the CHC plans to refine into a policy framework to work with the local health authority, mental health trust and local voluntary service providers.

Bolton CHC worked on a joint initiative in 1995 with Wigan and Bolton Health Authority and Bolton Ethnic Minorities Congress, with funding from the NHS Ethnic Health Unit. Its aims were to develop input from black and ethnic minority communities into the planning of health care.

In September 1996 it established the Ethnic Minorities Health Forum which examined four issues in its first year (coronary heart disease, diabetes, women's health and men's health).

The initiative was assessed by the Public Health Research and Resource Centre, University of Salford who identified its successes as "*getting people and organisations involved, setting up and running the Forum, raising awareness and work with other bodies.* " and that "*there have been valuable inputs to health planning but these now need to be established on a regular basis*" [16]

d. Dissemination of health information to black and ethnic minority groups

Dissemination of information can take a variety of forms. It would appear that the most common form employed by CHCs is producing leaflets in a variety of languages about particular health issues.

North Tees CHC and their local Trust were successful in 1995 in securing funds from the former NHS Ethnic Health Unit to undertake the production of a number of booklets in five ethnic languages describing the nature and array of health services in North Tees.

What is particularly interesting about this project is that the area has a fairly small black and ethnic minority population - 1.9% in the Tees Health Authority area[17]. North Tees CHC was able to win funding for the project based on an argument which explained that with such small black and ethnic minority groups locally their health needs were at greater risk from either being obscured or overlooked.

Ealing CHC have an Asian Health Advice Worker whose role is to provide advice and information on how people can voice "opinions/comments/complaints about health care services in the Ealing area"[18]. The service provides free and confidential advocacy in Punjabi, Hindi and Urdu, and is funded by the Department of Health.

Rotherham CHC also provide an interpretation and translation service for people whose first language is not English. However unlike Ealing CHC's service, Rotherham aims its service at other professionals working to help patients. "*This service aims to improve access to Community Care Services for people from local ethnic minority communities and is available free of charge to relevant [local authority] Social Services staff who work in Adult Services. A free service is also available to some local voluntary sector organisations.*" [19]

5. Conclusion

Established in 1974 to represent patients and give them a voice in the NHS, Community Health Councils (CHCs) are sometimes perceived as being white middle class organisations, unable to properly articulate the needs and concerns of the black and ethnic minority communities within their area.

The ACHCEW survey conducted in September 1996 was intended to be a snap-shot of CHC involvement in black and ethnic minority health issues: it cannot be seen as a definitive statement of the level of involvement. There is a clear pattern of urban CHCs demonstrating a higher involvement with black and ethnic minority issues than rural and geographically mixed CHCs. This could be explained by the greater concentration of black and ethnic minority groups in urban areas.

When the figures for the number of black and ethnic minority people in each health authority (see Appendix) are compared to CHC involvement in black and ethnic minority issues then a pattern can be observed.

Of the ten health authorities with the greatest percentage of black and ethnic minority residents in England, seven are in the North Thames Region - the region with the greatest CHC involvement in black and ethnic minority health issues. Of the ten health authorities with the lowest percentage of black and ethnic minority residents, five are in the South and West Region - the region with the lowest CHC involvement in black and ethnic minority issues. With considerable smaller resources (both in the number of staff and financial) it would unfair to draw comparisons between English CHCs and their Welsh counterparts.

It was encouraging to see just over half of all CHCs have formal or informal links with local black and ethnic minority groups. However less encouraging was the evidence that less than one in ten CHCs have a Race and Health Working Group to look at specific black and ethnic minority group health issues. However it could be argued that setting up a specific working group is not necessary for a CHC to be effective in this field.

In areas with small black and ethnic minority populations there is a real danger that these communities can be forgotten or ignored: yet their health needs still need to be reflected in service provision. It may be unfair to be overly critical of those CHCs with small numbers of black and ethnic minority people living in their area. CHCs have limited budgets and rely on members' time given voluntarily. They may well be aware of the issues but feel unable to devote any considerable resources into this area. Yet there are some CHCs that are particularly concerned with black and ethnic minority issues because of the small number of these communities within their area and the degree that their needs will be ignored as a result.

It is hoped that this report will stimulate discussion and help CHCs examine the way they address black and ethnic minority health.

Gary Fereday
May 1998
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Appendix A: "From here to equality".

The ACHCEW survey picked up on a number of the issues highlighted in Mandanna Hendessi's "From Here to Equality. CHCs Race and Ethnicity" (published in 1994 by the Greater London Association of Community Health Councils) and the follow up document "From Here to Equality: A Checklist for CHCs on Race and Ethnicity" (1996, the Greater London Association of Community Health Councils).

The checklist covered a wide range of issues covering the following areas:

- Equal opportunities policy.
- Recruitment, induction and support for members.
- Conduct of meetings.
- Reviewing CHC objectives.
- The role of the CHC Chair.
- The role of the CHC Chief Officer

At the time of this briefing being prepared these publications are still available from the Greater London Association of Community Health Councils.

Appendix B: Black and ethnic minority population by health authority in England

The table below shows the black and ethnic minority population as a percentage of the total population (DoH Statistics 1996):

Health Authority	
East London and the City	37.
Brent & Harrow	36.4
Ealing, Hammersmith & Hounslow	26.2
Lambeth, Southwark & Lewisham	25.7
Redbrigde and Waltham Forest	23.4
Birmingham	21.5
Enfield & Haringey	20.7
Kensington, Chelsea & Westminste	18.9
Wolverhampton	18.6
Barnet	18.4
Camden & Islington	18.4
Croydon	17.6
Bradford	15.6
Merton, Sutton & Wandsworth	14.9
Sandwell	14.7
Manchester	12.6
Hillingdon	12.3
Coventry	11.8
Leicestershire	11.1
Bedfordshire	9.9
Walsall	9.6
Bexley & Greenwich	9.2
Calderdale & Kirklees	8.6
East Lancashire	8.2
Berkshire	7.6
Kingston & Richmond	6.9
West Pennine	6.0
Nottingham	5.9
Bury & Rochdale	5.9
Leeds	5.8
Buckinghamshire	5.3
Sheffield	5.0

West Hertfordshire	4.9
Bromley	4.7
South Derbyshire	4.6
Barking & Havering	4.6
Dudley	4.5
Wigan and Bolton	4.2
Salford & Trafford	3.8
Liverpool	3.8
Northamptonshire	3.5
Warwickshire	3.4
North West Lancashire	3.4
North West Anglia	3.4
Oxfordshire	3.3
East & North Hertfordshire	3.1
West Kent	2.9
East Surrey	2.9
Solihull	2.9
Newcastle & North Tyneside	2.8
West Surrey	2.8
Avon	2.8
Cambridge & Huntingdon	2.6
Southampton & South West Hants	2.6
Stockport	2.4
Suffolk	2.2
North Staffordshire	2.0
South Essex	2.0
West Sussex	2.0
Rotherham	2.0
Tees	1.9
East Sussex, Brighton and Hove	1.9
Gloucestershire	1.8
North Essex	1.8
North and Mid Hampshire	1.8
South Staffordshire	1.7
Wiltshire	1.7
Shropshire	1.6
Doncaster	1.6
Portsmouth & South East Hants	1.5
Worcestershire	1.5
Wakefield	1.5
South Humber	1.3
East Kent	1.2
Gateshead & South Tyneside	1.1
Sunderland	1.1

North Cheshire	1.1
Wirral	1.0
Sefton	0.9
South Cheshire	0.9
South Lancashire	0.9
East Norfolk	0.9
Dorset	0.9
North Nottinghamshire	0.9
East Riding	0.9
St Helens and Knowsley	0.8
Morecambe Bay	0.8
Lincolnshire	0.8
County Durham	0.7
Isle of Wight	0.7
North Derbyshire	0.7
North Yorkshire	0.7
South and West Devon	0.7
North & East Devon	0.6
Barnsley	0.6
Herefordshire	0.6
Somerset	0.5
Cornwall & Isles of Scilly	0.5
Northumberland	0.5
North Cumbria	0.4

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