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Cumberland Council

Health Needs Assessment: Ethnic Minorities 2025

CUMBERLAND COUNCIL
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Executive summary

The health and well-being of ethnic minority populations in Cumberland are integral to achieving equitable healthcare outcomes. This Health Needs Assessment (HNA) explores the unique health challenges faced by these communities, with a focus on healthcare access, service utilisation, and health disparities. The assessment combines national and local quantitative data with qualitative insights from community leaders, focus groups, and service users to provide a comprehensive understanding of these issues.

Cumberland has seen a steady rise in its ethnic minority population, increasing from 1.53% in 2011 to 2.33% in 2021. However, health disparities persist, with ethnic minorities facing higher rates of chronic conditions, mental health challenges, and barriers to accessing primary care. This report highlights key findings and recommendations aimed at improving health equity for these communities.

Key Findings

Demographic and Geographic Insights

- The ethnic minority population in Cumberland is relatively small (2.33%) but growing. Most ethnic minorities are concentrated in urban areas, particularly Carlisle.
- Cumberland's minority communities tend to be younger than the White British population, with distinct health and social care needs.

Health Disparities and Chronic Conditions

- Ethnic minority populations face disproportionately high rates of diabetes, cardiovascular disease, and hypertension.
- Mental health concerns are prevalent, particularly among Black and Asian populations, yet underutilisation of mental health services is common due to stigma, lack of culturally appropriate services, and language barriers.
- Maternal health disparities are stark - Black women have nearly three times the maternal mortality rate of White women, and infant mortality rates are also higher among ethnic minority groups.

Barriers to Healthcare Access

- Language barriers significantly hinder access to services, with many non-English speakers struggling to book appointments or communicate effectively with healthcare providers.
- Trust issues exist between ethnic minority patients and healthcare services, with concerns about discrimination and a lack of cultural sensitivity leading to lower engagement.
- Ethnic minority communities are underrepresented in adult social care and preventive health programmes, suggesting limited outreach and engagement efforts.
- Over-reliance on emergency services: Due to difficulties accessing primary care, many ethnic minorities disproportionately use A&E services.

Service Utilisation and Gaps

- Lack of ethnicity data collection: Many healthcare providers do not systematically record ethnicity, making it difficult to track and address disparities effectively.
- Shortage of culturally competent care: There is a lack of culturally tailored health services and a need for greater diversity training among healthcare professionals.
- Limited awareness of services: Many ethnic minority residents are unaware of how to navigate the healthcare system, highlighting a need for better health literacy initiatives.

Key Recommendations

The recommendations are divided into Core and Supporting actions to enhance health equity for ethnic minority communities in Cumberland.

Core Recommendations (Systemic and Long-Term Changes)

Based on the findings, we propose five core recommendations:

1. **Improve Communication & Information Access** by embedding multilingual resources across all NHS and social care platforms to ensure patients can understand and engage with services.
2. **Expand Interpretation Services**, including on-demand phone and video support, and increasing the availability of trained interpreters across care settings.
3. **Require Ethnicity Data Collection** in all health and social care services to better identify disparities, monitor outcomes, and inform targeted interventions.
4. **Increase Access to Preventive Care** through culturally appropriate outreach, health education, and community-based initiatives that promote early intervention.

5. **Adopt Patient-Centred Approaches** by ensuring care is respectful, culturally competent, and co-designed with communities to build trust and responsiveness.

We've also identified three supporting actions to help put these into practice:

- **Implement Multi-Lingual Booking Systems** to ensure non-English speakers can navigate services with ease.
- **Provide Digital Access Support**, including Wi-Fi access in GP and community settings to support the use of translation tools and online services.
- **Strengthen Community Engagement** through partnerships with local organisations to co-design outreach and improve service relevance and uptake.

By implementing these recommendations, Cumberland Council can improve healthcare accessibility, reduce disparities, and foster trust between ethnic minority communities and health services.

Scope

This Health Needs Assessment focuses on the health outcomes, service access, and barriers experienced by ethnic minority communities in Cumberland. While local data collection on ethnicity and health has improved in recent years, significant challenges remain in obtaining a comprehensive, detailed analysis. Many healthcare and social care services do not systematically record ethnicity, making it difficult to assess disparities in service utilisation and outcomes accurately. Additionally, while this report aims to reflect the experiences of diverse ethnic groups, it was not feasible to engage with representatives from all ethnic minority communities due to resource and time constraints.

To maximise impact and ensure effective resource allocation, priority was given to ethnic groups with a significant presence in Cumberland, those experiencing documented health inequalities, and communities with active engagement networks. This approach was informed by census data, health service records, and input from local stakeholders. The assessment incorporates both quantitative data from national and local sources and qualitative insights gathered through interviews, focus groups, and community consultations.

Cumberland's geography presents unique challenges in healthcare access, particularly for ethnic minority communities. As a largely rural county with a dispersed population, service provision varies significantly between urban centres like Carlisle, where the majority of ethnic minorities reside, and more remote areas such as Allerdale and Copeland. Where specific data for these areas was unavailable, broader Cumbria-wide data has been used to provide relevant context.

It is important to note that this report does not specifically address the health needs of refugees and asylum seekers, as a dedicated Health Needs Assessment for this population was completed within the past year. Similarly, Gypsy, Roma, and Traveller communities were not included in this assessment, as they face distinct health challenges that require a specialised approach. A separate Health Needs Assessment focused on their unique circumstances, including housing stability, healthcare access, and cultural barriers, should be undertaken to ensure their specific needs are adequately addressed.

The findings aim to inform local policy, enhance service planning, and ensure equitable, culturally responsive healthcare in Cumberland. While data limitations persist, this report highlights areas where improved ethnicity data collection and further research are needed to address health disparities.

Overview and Context

Definition

Understanding the concept of ethnic minorities is essential for assessing and addressing health needs in diverse populations. A key part of this would be appropriately defining this population.

Ethnic minorities are defined as groups of people who share a common cultural background, language, or ancestry and differ in these aspects from the majority population within a society (Office for National Statistics, 2023). These groups often include people with distinct racial or ethnic identities who may face social, economic, or health disparities due to their minority status (Bhopal, 2014).

Background

The ethnic composition of Cumberland has evolved in recent decades, with significant growth in minority populations. According to recent census data, the proportion of ethnic minorities in Cumberland has increased from 1.53% in 2011 to 2.33% in 2021, although this remains lower than the average for both the Northwest and England as a whole (Office for National Statistics, 2023). Notably, the areas with the highest ethnic diversity are concentrated around Carlisle, where a diverse mix of Asian, Black, Arab, and other ethnic groups have become well-established in recent years. Understanding the specific health needs of these communities is critical as their numbers and contributions to the local area continue to grow.

This assessment uses both quantitative and qualitative data to capture a comprehensive picture of the health needs of Cumberland's diverse ethnic communities. Drawing on sources such as census data, hospital records, social care records, and local surveys, it also

incorporates direct feedback from focus groups, stakeholder interviews, and community leaders. This multifaceted approach allows us to identify both measurable health outcomes and nuanced, lived experiences, enabling a more complete understanding of the obstacles these communities face.

Introduction

The health and well-being of Cumberland's ethnic minority populations are integral to the overall health of our community. This Health Needs Assessment seeks to understand the unique challenges these groups face within local health and social care systems. Ethnic minority communities often experience disproportionate barriers to healthcare access, health inequalities, and specific health risks (NHS Race and Health Observatory, 2023). By identifying these challenges, this assessment aims to inform actionable steps to close health gaps, ensure equitable healthcare access, and ultimately improve health outcomes for all residents of Cumberland.

As Cumberland's ethnic minority population continues to grow, local services must adapt to meet the needs of increasingly diverse communities. Without proactive assessment and intervention, disparities in health outcomes and service access may widen, increasing reliance on emergency care and other reactive services. Understanding these emerging trends enables policymakers, healthcare providers, and community organisations to develop culturally competent, equitable, and responsive services. By acting now, Cumberland can improve long-term health outcomes, enhance community integration, and reduce health inequalities.

Ethnic minority populations often experience complex health challenges shaped by socioeconomic and cultural factors. In Cumberland, these communities face higher-than-

average rates of conditions such as cardiovascular disease, obesity, and diabetes. They also encounter significant barriers to healthcare access, including language difficulties, limited health literacy, and, at times, a lack of trust in healthcare providers. Additionally, low engagement with services like general practice out-of-hours (OOH) care, adult social care, and dental services suggests a gap in awareness or accessibility. A key barrier is the lack of comprehensive ethnicity data in healthcare records, limiting understanding of service use patterns and preventing targeted interventions.

National data and local insights consistently show that these challenges contribute to poorer health outcomes and reduced access to preventive care (NHS Race and Health Observatory, 2023). By addressing these disparities, Cumberland can move closer to achieving health equity and creating an inclusive healthcare system that meets the needs of all its residents. This needs assessment is a crucial step in that process, providing the evidence base to inform policy decisions, service planning, and the development of culturally responsive healthcare interventions.

Methodology

This chapter outlines the approaches taken to gather, analyse, and interpret data for the ethnic minority health needs assessment in Cumberland. This report employed both quantitative and qualitative methods to provide a comprehensive understanding of the health needs of ethnic minority communities. By combining statistical data with first-hand accounts from community members, the assessment was able to explore both measurable health disparities and the lived experiences that shape health outcomes within these groups.

Data Collection Methods

Quantitative Data Collection

Quantitative data was collected from multiple reliable sources to provide a foundational understanding of demographic trends, health service usage, and health outcomes for ethnic minority populations in Cumberland. Key sources for quantitative data included:

- Council Data: Local authority data provided insight into health service access, usage, and outcomes within Cumberland.
- National Data: Broader national statistics allowed for comparison between Cumberland and wider trends in England, placing local health indicators in a larger context.
- Census Data: Census information from 2011 and 2021 offered essential demographic insights, showing changes in the size and composition of ethnic minority populations over time.

- Hospital Records: Hospital records highlighted patterns in health service utilisation, such as emergency department attendance, and provided anonymised health outcome data for specific conditions.
- Surveys: Surveys conducted by public health authorities included data on health behaviours, service satisfaction, and access barriers.
- Cumbria Observatory: As a local data resource, Cumbria Observatory provided a range of socio-demographic data, health statistics, and indices of deprivation relevant to Cumberland.

Together, these sources contributed to a comprehensive picture of the health challenges facing ethnic minorities, their utilisation of healthcare services, and identified areas where disparities may exist.

Qualitative Data Collection

To understand the lived experiences of ethnic minorities and the barriers they face, qualitative data was collected directly from community members and leaders. This approach provided context to the quantitative findings and allowed for a deeper exploration of cultural, social, and practical challenges that may not be apparent in numerical data. Methods for collecting qualitative data included:

- Community Leader Interviews: Community leaders were interviewed to gain insight into the health concerns and needs of different ethnic groups. These interviews were informal 1 on 1 interviews in a location of their choosing. The questions were based on health perceptions and needs of ethnic minorities in the community, however there was no formal structure to these interviews.

- Focus Groups: Specially organised focus groups brought together members of various ethnic minority communities to discuss their experiences with health services. These groups allowed for shared experiences to be voiced and provided insights into common barriers, cultural attitudes, and expectations around health and healthcare. These groups included interpreters, to widen the scope of participants who could attend. There were a maximum of 12 participants per session. The focus groups were more structured, and a template was designed and followed (see appendix)
- Opportunistic Interviews: Opportunistic interviews were conducted at community events, clubs, and gatherings. These interviews were informal and followed no specific structure. This informal approach facilitated engagement with individuals who might not otherwise participate in organised focus groups, adding diversity to the qualitative sample and capturing perspectives from a broad range of community members.

The qualitative data provided rich insights into cultural nuances, health beliefs, and practical challenges that contribute to health inequalities. This data was crucial for contextualising quantitative findings and ensuring the assessment captured a full spectrum of experiences.

Data Analysis

Quantitative Analysis: The quantitative data was analysed to identify trends and disparities in health outcomes, service utilisation, and demographic changes. Statistical comparisons were made where possible to highlight differences between ethnic minority populations in Cumberland and the general population, both locally and nationally. By examining factors such as hospital attendance rates, prevalence of chronic conditions, and social care

utilisation, the assessment identified key areas where ethnic minorities face distinct health challenges.

Qualitative Analysis: The qualitative data from focus groups, interviews, and community leader discussions was thematically analysed to identify recurring topics, concerns, and patterns. Major themes, such as language barriers, cultural perceptions of healthcare, and access difficulties, were categorised and explored in relation to the quantitative findings. This thematic analysis allowed the identification of common barriers and highlighted specific needs within ethnic minority communities that might require tailored interventions.

Strengths and limitations

Strengths

Comprehensive Approach: By combining quantitative and qualitative methods, the assessment provided a well-rounded understanding of ethnic minority health needs, highlighting both measurable trends and individual experiences.

Multiple Data Sources: The use of diverse data sources, from local council data to national census data, strengthened the reliability and relevance of the findings. Each data source added a unique perspective, helping to capture the complexity of health needs within Cumberland's ethnic minority populations.

Community Engagement: Direct engagement with community members and leaders added depth to the findings and ensured that the voices of those affected by health disparities were represented. This approach fostered trust and enabled the collection of authentic, nuanced information about community health perceptions and barriers.

Limitations

Engagement Gaps: While not every ethnic minority group in Cumberland was directly engaged in this assessment, efforts were made to validate findings through triangulation with multiple data sources, including national and regional statistics, previous health needs assessments, and stakeholder interviews. This approach helped to mitigate gaps in direct engagement and ensured that key themes and barriers identified align with broader evidence on ethnic minority health disparities.

Data Gaps: Certain quantitative sources lacked detailed breakdowns by ethnicity, which limited the ability to conduct granular analyses for specific groups. There were a lot of gaps with specific Cumberland statistics when it came to ethnic minority populations, so in many cases assumptions were made for a Cumberland context based on national data.

Self-Selection Bias in Qualitative Data: Participation in focus groups and interviews was voluntary, which could introduce self-selection bias. Those who chose to participate may be more engaged or have more pronounced concerns than other community members. This limitation may affect the generalisability of qualitative findings to the entire ethnic minority population.

Limited Sample Sizes in Qualitative Data: Due to the small size of some ethnic groups in Cumberland, qualitative data for certain communities may be limited. While efforts were made to reach diverse voices, small sample sizes could mean that some specific needs or perspectives are underrepresented.

Temporal Constraints: The timing of data collection may impact the findings, especially as ethnic demographics in Cumberland continue to change. Future reassessments will be needed to capture evolving health trends and emerging issues within ethnic minority populations.

The methodology for this health needs assessment aimed to provide a comprehensive, balanced view of the health status and needs of ethnic minorities in Cumberland. The integration of quantitative data from reliable sources and qualitative insights from community engagement allowed for a robust analysis of health disparities, service utilisation, and the broader social determinants of health affecting these populations. While limitations in data availability and potential biases are acknowledged, the methodology ensures that this assessment serves as a valuable foundation for developing inclusive, responsive health policies and interventions tailored to Cumberland's diverse communities. Future assessments should continue to address data gaps and expand engagement with community members to build upon these findings.

Demographic Profile: Overview of the ethnic minority populations in Cumberland

Cumberland's ethnic minority population, while still smaller than regional and national averages, is steadily growing. According to the 2021 Census, 2.33% of Cumberland's population identifies as belonging to an ethnic minority group, compared to 14.43% in the Northwest and 18.96% in England overall whole (Office for National Statistics, 2023). This marks an increase from 2011, when ethnic minorities constituted 1.53% of Cumberland's population.

In the wider context of Cumbria, which has a total population of 499,800, 94.9% of residents identify. Across Cumbria, 5.1% of residents identify as belonging to an ethnic minority group (including White minorities), up from 3.6% in 2011 (Cumberland Council, 2021). This represents a notable proportional increase, mirroring broader national trends in ethnic diversity.

Cumberland's diversity profile aligns with the overall trends in Cumbria but varies when compared to specific areas within the county. For example, Allerdale and Copeland hold the distinction of having the highest proportions of residents identifying as White British nationally and the lowest proportions of ethnic minority residents (including White minorities) (Cumberland Council, 2021). This reflects a relatively less diverse demographic makeup compared to Cumberland as a whole.

These shifts indicate an ongoing increase in diversity within Cumberland and Cumbria overall, with implications for local health and social care services. The changing demographic landscape emphasises the need for culturally competent care and targeted interventions to address the unique health and social needs of minority groups in the area.

Ethnic Group	Cumberland %	Northwest %	England %
White	97.7	85.6	81.0
Asian/Asian British	1.0	8.4	9.6
Black/Black British	0.2	2.3	4.2
Mixed	0.8	2.2	3.0
Other Ethnic Groups	0.4	1.5	2.2

Table 1: Population of Ethnic Minorities in Cumberland/Northwest/England (ONS – Census 2021)

Changes over time

Between 2011 and 2021, Cumberland experienced notable changes in its ethnic composition. While the overall population decreased slightly from 274,549 to 273,254, the number of individuals identifying as part of an ethnic minority group increased significantly. For example:

- The Asian/Asian British population grew by 15%.
- The Black/Black British population doubled, rising from 0.1% to 0.2% of the total population.
- Conversely, the White population decreased from 270,356 in 2011 to 266,889 in 2021.

What we can gather from table 1 is the sizeable difference in proportion of ethnic minorities living in Cumberland, as compared to the northwest and England as a whole. In England, ethnic minorities make up nearly 20% of the population. However, in Cumberland it is less than 3%. It implies Cumberland is much less diverse than the rest of the country. What is

noteworthy is the increase in the ethnic minority population from 1.53% to 2.33%, it tells us that the ethnic minority population is growing and may require more tailored approaches when it comes to improving the health of the population.

Ethnic minority Population Distribution

Ethnic minority population (total)	Allerdale	Carlisle	Copeland
White	94,667	106,508	65,714
Asian/Asian British	540	1628	547
Black/Black British	84	337	185
Mixed	627	973	450
Other Ethnic Groups	253	579	180

Table 2: Ethnic minority distribution per District (ONS - Census 2021)

Based on this data we can see that most of the ethnic minority communities are concentrated in the Carlisle area. The concentration of the ethnic minority population, particularly Asian/Asian British groups, in Carlisle has important implications for health needs assessment (HNA) and service provision. As the largest urban area in Cumberland, Carlisle offers greater access to employment, education, and public services, which are key drivers for ethnic minority settlement (City of Carlisle, 2024). This clustering often leads to the formation of distinct cultural communities, which can foster social cohesion and support for newer arrivals. However, it also highlights the potential for concentrated health and social care needs, including language support, culturally specific health promotion, and access to culturally competent services.

From a health planning perspective, the concentration of ethnic minorities in Carlisle underscores the need for targeted and equitable resource allocation. Ethnic minority groups

may face unique health challenges, including higher risks for certain conditions like diabetes and cardiovascular disease or barriers to accessing preventive healthcare (Gumber and Gumber, 2017), (NHS Race and Health Observatory, 2023). Public health interventions must consider these factors while addressing potential inequalities. Additionally, engagement with community leaders and culturally tailored programmes will be critical to ensuring that services are inclusive and effective in meeting the needs of this population, ultimately contributing to reducing health disparities and promoting better outcomes across the community.

Age and Sex

Analysing the age and sex distribution of ethnic minority populations in Cumberland provides insight into the region's demographic dynamics, especially when compared to national trends.

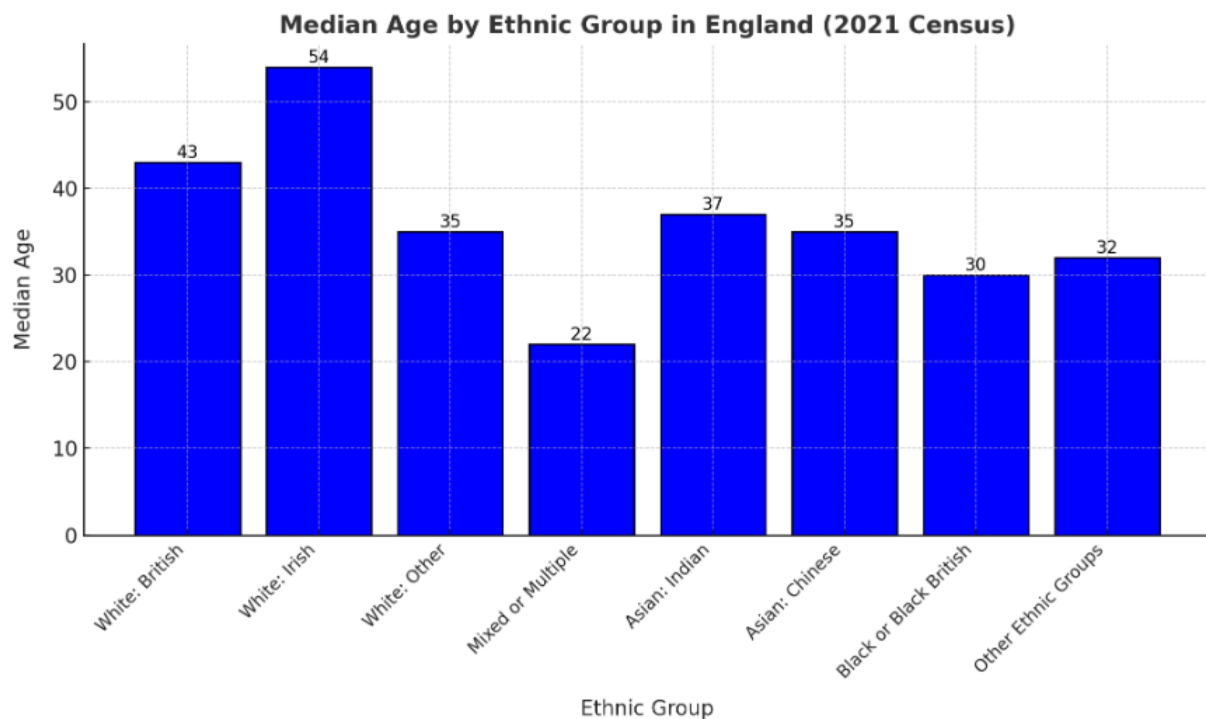
Age Distribution

Detailed data on age distribution by ethnicity specific to Cumberland is not readily available. However, national trends from the 2021 Census for England and Wales provide valuable insights into likely patterns. Ethnic minority populations tend to have younger age profiles compared to the predominantly older White British population (Office for National Statistics, 2023). For example, the median age for the Asian ethnic group nationally is 30 years, compared to 43 years for the White British group (see graph 1). This would reflect higher fertility rates and a younger migrant population within ethnic minority groups.

The overall median age in Cumberland is 46.8 years, indicating an older population compared to the national average (Varbes, 2022), (Office for National Statistics, 2023).

England

According to the 2021 Census for England and Wales, the median ages for various ethnic groups are as follows:



Graph 1: Median Age of Ethnic Minorities in England (ONS – Census 2021)

Nationally, the White British population has a higher median age (43 years) compared to most ethnic minority groups, reflecting an older demographic. In contrast, ethnic minority groups tend to have younger median ages, with the Mixed or Multiple Ethnic Groups category being the youngest at 22 years.

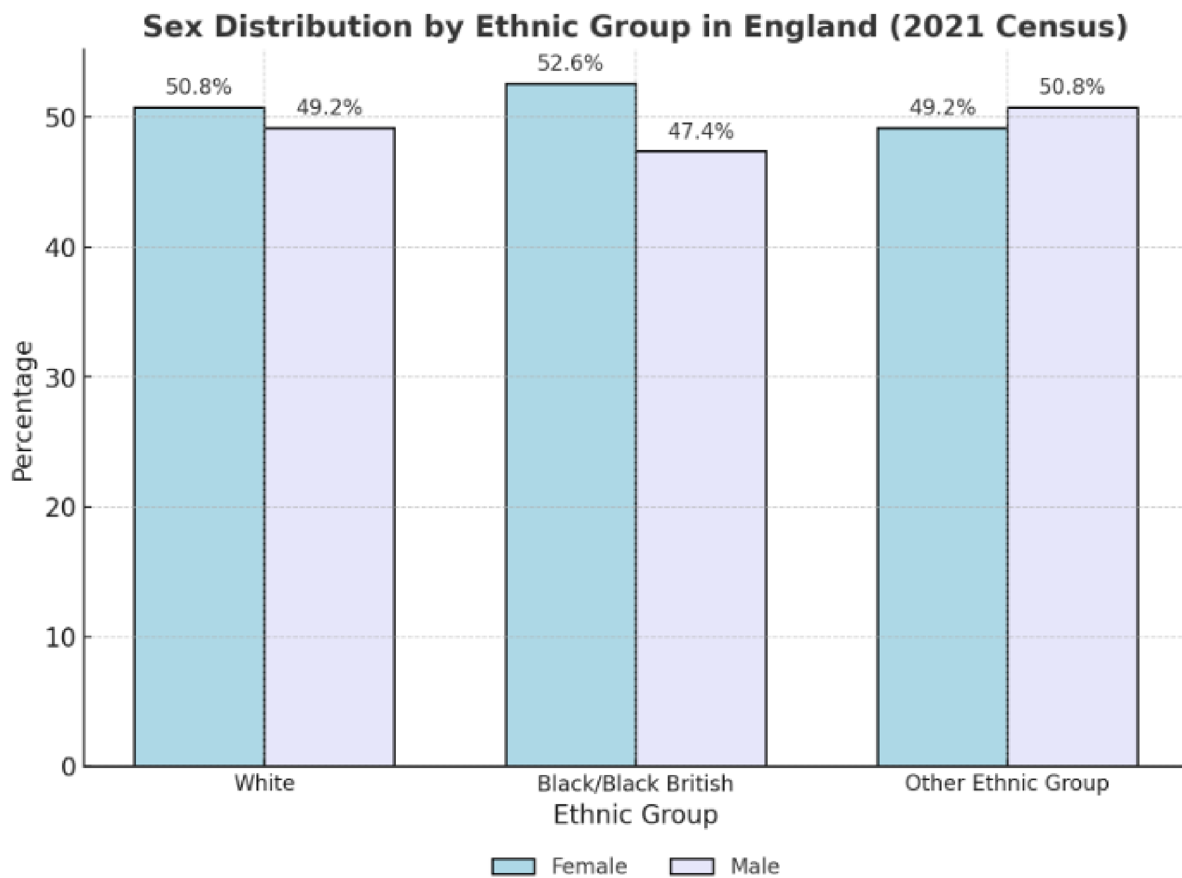
While specific data for Cumberland's ethnic minority median ages is not available, it is reasonable to infer that, like national trends, these groups may have younger median ages compared to the White British population. However, given Cumberland's overall higher median age, the median ages for all ethnic groups in the region might be slightly higher than the national figures.

In Cumberland, where ethnic minorities make up approximately 2.3% of the population, it is plausible that these groups similarly exhibit younger age profiles. This demographic dynamic has implications for health and social care planning. Younger populations may require focused investment in areas such as maternity services, paediatric care, and educational outreach (NICE, 2021). Conversely, the predominantly older White British population may necessitate more resources for geriatric care (NHS England, 2019). While Cumberland's ethnic minority population remains small, understanding their distinct age distribution is essential for developing equitable and responsive services tailored to both ends of the age spectrum.

Sex

According to the 2021 Census for England and Wales, the overall population comprised 51.0% females and 49.0% males. The sex distribution varied across different ethnic groups:

- Black, Black British, Black Welsh, Caribbean or African: 52.6% female
- Other ethnic group: 49.2% female
- White: 50.8% female



Graph 2: Sex distribution by Ethnicity in England (ONS – Census 2021)

Nationally, most ethnic groups have a higher proportion of females than males, with the "Black, Black British, Black Welsh, Caribbean or African" group having the highest percentage of females at 52.6%. The "Other ethnic group" category has a slightly higher proportion of males, with females constituting 49.2%.

In Cumberland, while specific sex distribution data by ethnic group is not available, the overall near 50/50 split aligns with national trends. However, local factors such as health inequalities and deprivation may influence sex distribution in older age groups.

Language

Language proficiency is a key determinant of access to services, social integration, and overall well-being (Migration Observatory, 2020), (Li and Wang, 2021). In Cumberland, the

2021 Census highlights a predominantly English-speaking population, with 97.7% of residents reporting English as their main language, slightly down from 98.3% in 2011. This remains significantly higher than the regional average in the Northwest (94.4%) and the national average for England (90.8%). Residents whose main language is not English have increased from 1.7% in 2011 to 2.3% in 2021, reflecting a gradual increase in linguistic diversity within the county.

While the proportion of non-English speakers in Cumberland remains relatively small, the ability to speak English varies significantly. In 2021, 1.2% of Cumberland residents with a main language other than English reported speaking English "very well," and 0.8% stated they spoke English "well." However, a smaller proportion reported difficulties, with 0.3% stating they could not speak English "well" and 0.06% unable to speak English at all. These figures have risen slightly since 2011, aligning with regional and national trends that show a growing need for targeted language support services to ensure inclusivity in public health, education, and community engagement.

The table below provides a detailed comparison of language proficiency between Cumberland, the Northwest region, and England, alongside changes from 2011 to 2021. It underscores Cumberland's relatively high levels of English proficiency compared to broader benchmarks while highlighting the incremental increases in linguistic diversity over the past decade. These trends point to the importance of accessible language assistance services and culturally competent communication strategies to address the needs of non-English speaking residents effectively.

Proficiency Level	Cumberland (2011)	Cumberland (2021)	North West (2011)	North West (2021)	England (2011)	England (2021)
Main language is English	98.3%	97.7%	95.4%	94.4%	92.0%	90.8%
Main language is not English:	1.7%	2.3%	4.6%	5.6%	8.0%	9.2%
- Can speak English very well	0.9%	1.2%	2.5%	3.0%	4.0%	4.3%
- Can speak English well	0.6%	0.8%	1.5%	1.8%	2.3%	2.5%
- Cannot speak English well	0.2%	0.3%	0.5%	0.6%	1.2%	1.5%
- Cannot speak English	0.04%	0.06%	0.1%	0.2%	0.3%	0.4%

Table 3: English Proficiency of Ethnic Minorities in England in 2011 and 2021 (ONS – Census 2011/2021)

These insights emphasise the importance of proactive measures to support individuals with limited English proficiency in accessing services and participating in community life. By addressing language barriers, Cumberland can ensure equitable service delivery and foster social cohesion, benefiting the county's increasingly diverse population.

Implications of the Demographic trends

The demographic trends observed in Cumberland, particularly the growth of the ethnic minority population, have significant implications for health and social care planning. While the overall population in Cumberland has slightly decreased, the ethnic minority population has grown by over 50% between 2011 and 2021 (Office for National Statistics, 2023). This shift highlights the need for public services to adapt to the needs of a more diverse community.

One immediate implication is the increasing demand for culturally competent healthcare services. Ethnic minority populations often face unique health challenges, such as a higher prevalence of diabetes, cardiovascular diseases, and maternal health concerns (NHS Race and Health Observatory, 2023). The clustering of ethnic minorities in Carlisle further underscores the need for targeted interventions in urban areas. Programmes tailored to specific cultural and language needs, such as dietary education for diabetes management or culturally sensitive mental health support, will be critical in addressing these disparities.

The linguistic diversity indicated by the growing number of non-native English speakers, particularly in schools, signals the need for expanded language support services. Without such support, language barriers can exacerbate inequalities in accessing healthcare, education, and social care (Care Learning, 2024). For example, residents with limited English proficiency may struggle to navigate the healthcare system, leading to delayed care and over-reliance on emergency services. Investing in interpretation services, multilingual health promotion materials, and community-based outreach programmes will be crucial to bridging these gaps.

The younger age profile of ethnic minority populations compared to the predominantly older White British population also has significant implications. While the ageing White British population will require increased investment in geriatric and end-of-life care, the younger ethnic minority population may demand expanded maternal, paediatric, and educational services. This dual demand highlights the need for strategic resource allocation to ensure that services meet the needs of both groups equitably.

Projected Future Trends

If these trends persist, Cumberland's ethnic minority population will likely continue to grow, both in absolute numbers and as a proportion of the total population. This ongoing demographic shift could have long-term implications for the council:

1. **Health Inequalities May Widen**: Without proactive measures, the health disparities already observed among ethnic minority populations could increase. Barriers to accessing primary care, language challenges, and limited culturally tailored interventions could exacerbate existing gaps in health outcomes.

2. **Urban Resource Strain**: The concentration of ethnic minorities in Carlisle suggests that this area may experience disproportionate demand for healthcare, housing, and education services. The council will need to ensure equitable resource distribution to prevent overburdening urban systems while addressing the needs of smaller, more dispersed minority populations in rural areas.

3. **Workforce and Economic Contributions**: A younger, growing ethnic minority population represents an opportunity to address workforce shortages, particularly as the White British population ages. Ensuring access to education, skills training, and employment opportunities for these communities will be essential for fostering economic growth and integration.

4. **Cultural and Social Integration**: Continued growth in ethnic diversity may require sustained efforts to promote social cohesion. Programmes fostering intercultural dialogue, anti-discrimination policies, and community integration initiatives will be critical to maintaining harmony in increasingly diverse neighbourhoods.

5. **Language Support Expansion**: With more non-native English speakers expected, particularly among children and young families, schools and public services will need to prioritise multilingual resources. This may include hiring bilingual staff, providing language education for adults, and leveraging technology to support communication in healthcare and social care settings.

Health Status: Detailed findings on health issues, service utilisation, and barriers.

Understanding the health status of ethnic minority populations is crucial for addressing health disparities and promoting equity in Cumberland. This section examines key health indicators for ethnic minorities locally, compares them with national trends, and highlights areas requiring targeted intervention.

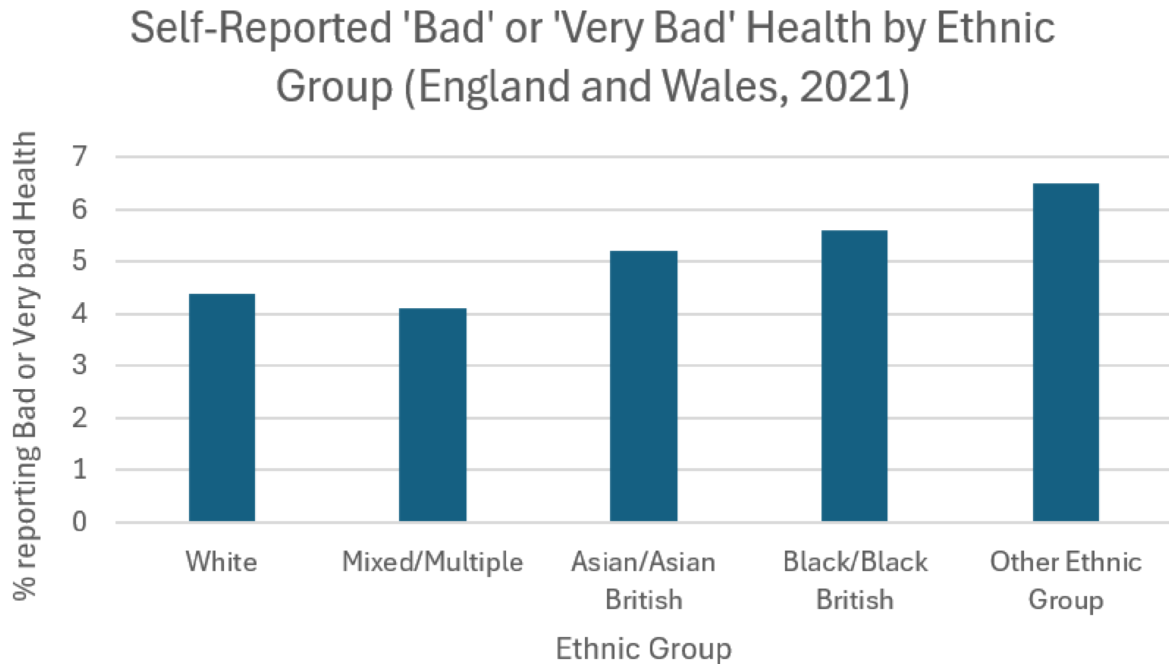
General Health Perceptions

According to the 2021 Census, 82% of Cumberland's population reported their health as "good" or "very good," slightly below the national average of 85%. While specific data for ethnic minorities in Cumberland are not readily available, national trends provide valuable context. The Office for National Statistics has published data on general health status by ethnic group in England and Wales, which can be used to infer potential patterns in Cumberland.

The table below presents the age-standardised percentages of self-reported general health by ethnic group in England and Wales:

Ethnic Group	Very Good/Good Health (%)	Fair Health (%)	Bad/Very Bad Health (%)
White	82.0	13.6	4.4
Asian/Asian British	81.5	13.3	5.2
Black/Black British	80.7	13.7	5.6
Mixed	83.7	12.2	4.1
Other Ethnic Groups	79.5	14.0	6.5

Table 4: Self-reported Health of Ethnic Minorities in England and Wales (ONS – Census 2021)



Graph 3: Self-reported Bad/Very Bad Health of Ethnic Minorities in England and Wales (ONS – Census 2021)

The above table and graph indicate that, at the national level, individuals from any ethnic minority background are more likely to report "bad" or "very bad" health compared to the White population. This trend is influenced by various factors, including socioeconomic disparities and longstanding health inequalities (The Kings Fund, 2023).

Given that Cumberland's ethnic minority population is small but growing, it is reasonable to assume that similar health perception patterns may exist locally. This underscores the importance of conducting further research to obtain specific data for Cumberland's ethnic groups and implementing tailored interventions to address their unique health needs.

Chronic Conditions

Ethnic minority populations often face a higher prevalence of certain chronic conditions due to genetic predispositions, lifestyle factors, and socioeconomic determinants. Nationally, key trends include:

Diabetes: South Asian and Black African/Caribbean communities are up to six times more likely to develop Type 2 diabetes compared to White British populations (Gumber and Gumber, 2017). This trend is associated with genetic susceptibility, dietary habits, and barriers to accessing preventative care.

Cardiovascular Disease (CVD): South Asian groups have a higher risk of coronary heart disease, while Black communities are more prone to hypertension and stroke (NHS Race and Health Observatory, 2023). These conditions are often exacerbated by limited access to early intervention programmes.

Obesity: Ethnic minority groups have varying obesity rates. Black adults, especially women, have significantly higher obesity rates nationally compared to the white population (Office for Health Improvement and Disparities). Data from the Office for Health Improvement and Disparities indicates that 72% of Black adults are classified as overweight or obese, compared to 64.5% of White British adults. This disparity is more pronounced among women, with 38% of Black women being obese compared to 29% of White British women.

Implications for Cumberland: While local data on these conditions are limited, qualitative findings suggest that South Asian and Black communities in Cumberland may share these heightened risks.

Mental Health

Mental health outcomes among ethnic minorities are shaped by a complex interplay of socioeconomic, cultural, and systemic factors. National data from the Adult Psychiatric Morbidity Survey (APMS) 2014 reveals stark disparities in both the prevalence of mental health conditions and access to care across ethnic groups (NHS Digital, 2016). These findings

are crucial for understanding and addressing the unique challenges faced by ethnic minority populations.

Prevalence of Common Mental Disorders (CMD) by Ethnicity

Common mental disorders (CMDs), such as anxiety and depression, are prevalent across all ethnic groups but disproportionately affect Black/Black British and other minority populations. Table 5 illustrates the percentage of individuals reporting CMDs in the past week by ethnic group:

Ethnic Group	Any Common Mental Disorder (%)
White British	17.3
White Other	14.4
Black/Black British	22.5
Asian/Asian British	17.9
Other Ethnic Groups	19.5

Table 5: Percentage of ethnicities with a CMD diagnosis over the past week (APMS Data 2014)

Notably, Black/Black British individuals report the highest prevalence of CMDs (22.5%), significantly exceeding the national average for White British individuals (17.3%). Similarly, other ethnic groups, including Mixed and multiple ethnicities, also show elevated rates of CMDs (19.5%).

Access to Mental Health Treatment

Despite higher prevalence rates in some ethnic minority groups, access to mental health treatment remains a significant barrier. Table provides data on treatment uptake by ethnicity:

Ethnic Group	No Treatment (%)	Treatment (%)
White British	85.5	14.5
White Other	92.4	7.6
Black/Black British	93.5	6.5
Asian/Asian British	92.9	7.1
Other Ethnic Groups	92.6	7.4

Table 6: People receiving treatment for mental health disorders by Ethnicity (APMS Data 2014)

While 14.5% of White British individuals receive treatment, this figure drops to just 6.5% among Black/Black British individuals and 7.1% for Asian/Asian British individuals. These disparities suggest that ethnic minorities are significantly underrepresented in mental health service utilisation, likely due to systemic barriers such as stigma, cultural insensitivity, and inadequate outreach (Alam et al, 2023).

Cultural Attitudes and Stigma

Mental health stigma remains a pervasive issue, particularly within South Asian, Arab, and some African communities (Mental health foundation, 2024). This cultural reluctance to seek care often delays or prevents treatment.

Socioeconomic Factors

Higher rates of poverty, unemployment, and housing insecurity in minority populations contribute to mental health disparities, exacerbating CMD prevalence (The Kings Fund, 2023). The King's Fund report discusses that socio-economic deprivation is a key determinant of health status in all communities, with most ethnic minority groups disproportionately affected. Structural racism can reinforce inequalities in housing, employment, and the criminal justice system, which in turn negatively impact health.

Systemic Barriers

Minority populations often encounter significant challenges in accessing culturally competent care, with services frequently failing to address language needs, cultural norms, or specific stressors related to racial discrimination (Ali and Watson, 2018). This study published in the Journal of Clinical Nursing highlights that language barriers hinder effective communication between patients and nurses, underscoring the necessity of professional interpreters to enhance culturally competent and patient-centred care.

Maternal and Child Health

Recent data from the UK highlights significant disparities in maternal and child health outcomes among different ethnic groups. These differences are influenced by factors such as socioeconomic status, access to healthcare, cultural barriers, and systemic inequalities (British Journal of Midwifery, 2021).

Ethnic Group	Maternal Mortality Rate (per 100,000 maternities)	Relative Risk Compared to White Women
White British	12.23	1
Asian/Asian British	20.16	1.65
Black/Black British	35.10	2.87
Chinese/Others	8.44	0.69
Mixed Ethnic Groups	16.34	1.34

Table 7 Maternal Mortality Rates by Ethnic Group (MBRRACE-UK, 2020–2022)

Ethnic Group	Infant Mortality Rate (per 1,000 live births)
White British	2.8
Asian/Asian British	4.3
Black/Black British	6.1
Mixed Ethnic Groups	3.2

Table 8: Infant Mortality Rates by Ethnicity 2022 (ONS – 2022)

These statistics reveal persistent and significant disparities in maternal and infant health outcomes among different ethnic groups in the UK. Black women face a maternal mortality rate nearly four times higher than White women, while Asian women have a rate almost twice as high. Similarly, infant mortality rates are highest among Black and Asian populations compared to White populations.

Addressing these disparities would require targeted interventions, for example, tackling underlying socioeconomic determinants that contribute to health inequalities and improving data collection practices. By focusing on these areas, it is possible to work towards equitable maternal and child health outcomes across all ethnic groups.

5.5 Physical Activity

Physical activity levels in England vary significantly across different ethnic groups, influenced by factors such as socioeconomic status, cultural norms, and access to recreational facilities (GOV, 2023). Understanding these disparities is crucial for developing targeted interventions to promote physical activity among all communities.

Ethnic Group	England (%)	Northwest (%)
All	63.1	61.3
White British	64.4	62.7
White Other	66.8	65.8
Asian	55.0	48.3
Black	56.1	53.1
Chinese	60.4	67.4
Mixed	70.8	71.4
Other Ethnicity	54.7	53.0

Table 9: Physical Activity Levels by Ethnic Group in England (Active Lives Survey, 2021–2022)

Nationally, individuals from Mixed ethnic backgrounds exhibit the highest levels of physical activity, with 70.8% meeting the recommended 150 minutes of moderate-intensity exercise per week. This is significantly higher than the national average of 63.1% and highlights a positive trend within this group. In contrast, individuals from Asian (55.0%), Black (56.1%), and Other ethnic groups (54.7%) have the lowest activity levels, falling well below the national average. White British and White Other groups show moderately higher activity levels, at 64.4% and 66.8%, respectively, indicating a closer alignment with national trends.

In the Northwest region, physical activity levels are generally lower across all groups compared to national averages. The Mixed ethnic group remains the most active (68.0%), while the Asian (52.0%) and Other (53.0%) groups continue to record the lowest levels of physical activity. This regional disparity suggests that local factors, such as access to recreational facilities, socioeconomic conditions, or tailored community programmes, may influence participation rates. These patterns indicate a pressing need for targeted

interventions to address the unique challenges faced by different ethnic groups within the Northwest.

The data suggests that physical activity engagement is influenced not only by ethnic background but also, possibly, by regional factors. For example, individuals in the Northwest might face additional barriers to accessing physical activity opportunities, such as fewer community programmes or recreational spaces. However, the consistently lower activity levels among "Asian," "Black," and "Other" groups indicate potential cultural, socioeconomic, or systemic challenges that disproportionately affect these communities.

Sexual health

Sexually transmitted infections (STIs) disproportionately affect certain ethnic groups, with significant disparities in both diagnosis rates and access to sexual health services. Understanding these differences is essential for addressing inequalities and improving health outcomes. This section examines regional and national data to highlight key trends and inform targeted interventions for Cumberland's diverse population.

Ethnic Group	2022 numbers	2023 numbers	2022 rates	2023 rates
White	241,948	248,186	528.5	542.1
Asian/Asian British	18,375	21,619	338.6	398.4
Black/Black British	36,586	40,275	1,536.1	1,691.0
Mixed	21,897	24,517	1,311.7	1,468.6
Other Ethnic Groups	8,261	9,588	672.1	780.0

Table 10: England new STI diagnosis and rates by ethnic group (UKHSA – 2023)

Ethnic Group	2022 numbers	2023 numbers	2022 rates	2023 rates
White	34,186	34,977	538.6	551.0
Asian/Asian British	1,376	1,752	221.0	281.4
Black/Black British	1,841	2,220	1,058.5	1,276.4
Mixed	1,803	2,041	1,104.4	1,250.2
Other Ethnic Groups	675	731	612.8	663.6

Table 11: Northwest new STI diagnosis and rates by ethnic group (UKHSA – 2023)

The data highlights a disproportionate burden of STIs on ethnic minority groups, particularly among Black/Black British and Mixed ethnicities. These groups consistently show the highest rates of STI diagnoses both regionally and nationally, reflecting significant disparities in sexual health outcomes. This emphasises the need for targeted public health interventions to address the unique challenges faced by these populations, such as cultural stigma, limited access to healthcare, or socio-economic barriers (Hunt et al, 2023).

In contrast, the White population exhibits the highest absolute number of STI diagnoses, but the rate per 100,000 remains significantly lower compared to minority groups. This suggests that while the White population accounts for a larger share of cases due to their demographic majority, the relative burden of STIs is less pronounced, indicating more equitable access to prevention and treatment services or lower levels of sexual health risk factors in this group.

Comparing regional trends in the Northwest to national data reveals a consistent pattern of disparities, but with slightly higher rates observed nationally across all ethnic groups. This may indicate regional differences in access to sexual health services, variations in testing practices, or differences in population risk factors.

The overall upward trend in STI rates among Asian/Asian British and Other ethnic groups signals growing sexual health needs in these communities. While their rates remain lower compared to Black and Mixed groups, the significant year-on-year increases highlight a need for proactive measures to address potential barriers to accessing care and to prevent further disparities.

Vaccination/Vaccination Hesitancy

Vaccination coverage and hesitancy vary significantly across ethnic groups, reflecting underlying disparities in healthcare access, trust, and systemic barriers. While the White British population consistently achieves high vaccination rates, many ethnic minorities experience significantly lower coverage for routine childhood vaccinations. These disparities highlight the urgent need to understand and address the specific factors contributing to vaccine inequities to improve public health outcomes and equity. Looking at the following tables from the ONS and electronic health records from the Clinical Practice Research Datalink (CPRD) we can see how vaccination coverage is impacted by ethnicity.

Ethnic Group	MMR Coverage (Primary, %)	MMR Coverage (Full, %)	4-in-1 Coverage (Primary, %)	4-in-1 Coverage (Full, %)
White British	95	90	94	91
Indian	94	89	93	89
Pakistani	93	88	91	88
Bangladeshi	92	87	90	87
Chinese	94	89	93	89
Mixed White-Asian	92	88	91	88
Caribbean	61	61	61	61
Any Other Black, African, or Caribbean	68	68	68	66

Table 12: Vaccine coverage in England by Ethnicity between 2006 and 2021 (Zhang et al, 2023)

Ethnic Group	Covid vaccine/Vaccine Hesitancy (%)
White	8
Asian/Asian British	16
Black/Black British	44
Mixed	17
Other Ethnic Groups	18

Table 13 – Covid vaccine/Vaccine Hesitancy in England 2021 (ONS – Lifestyles Survey 2021)

Disparities in vaccination coverage across ethnic groups pose significant public health challenges. The simplified table shows that White British children consistently achieve high vaccination rates, exceeding 90% for both MMR and 4-in-1 vaccines, reflecting good healthcare access, trust, and understanding of vaccinations.

In contrast, minority groups, particularly Caribbean and Black populations, have much lower coverage (61%-68%), far below national averages and targets. This aligns with COVID-19 vaccine hesitancy trends, where 44% of Black/Black British individuals reported hesitancy compared to 8% in Whites, highlighting barriers such as healthcare access, language issues, and structural racism.

Some groups, like Indian and Chinese populations, achieve comparable rates to White British children (92%-94%), suggesting tailored interventions and cultural factors may improve uptake. Pakistani, Bangladeshi, and Mixed White-Asian groups show intermediate coverage (around 90%), with a decline for full courses, indicating the need for ongoing public health engagement.

Although these figures are more representative of national levels, we can assume that Cumberland will follow similar trends. While the White British group's high rates show the

system's effectiveness, it must be adapted to meet the needs of underserved groups to improve equity and prevent disease outbreaks.

Service Utilisation, Access Barriers, and Gaps in Provision

Patterns of Service Utilisation

Ethnic minorities in Cumberland exhibit distinct patterns of health and social care utilisation, which reflect broader systemic and cultural challenges. Data indicates that:

- **Emergency Services**: Hospital records show a disproportionate reliance on Accident & Emergency (A&E) services among ethnic minority groups. Although they make up approximately 2.3% of the population, ethnic minorities are overrepresented in A&E attendance. This trend mirrors national findings that highlight higher emergency care usage among communities with limited access to primary care.
- **Adult Social Care**: Ethnic minorities account for less than 1% of adult social care referrals in Cumberland, significantly lower than their population proportion. This indicates potential barriers in navigating referral systems and accessing culturally appropriate support services.

Gaps in Data and Service Provision

- **Data Gaps**:
    - Many health and social care services in Cumberland do not systematically collect ethnicity data, particularly in GP out-of-hours (OOH) services. This limits the ability to identify disparities in service utilisation and health outcomes.

- Limited local data on chronic conditions, mental health outcomes, and social care needs for ethnic minorities restricts the ability to plan and deliver targeted interventions.

Hospital attendance

The ethnic composition of Cumberland is evolving, as reflected in the increasing attendance of ethnic minority groups at the Cumberland Infirmary Accident and Emergency (A&E) department from 2020 to 2022. This section uses the latest data to explore proportional changes in A&E utilisation by ethnic minorities, identifying trends and implications for Cumberland Council's healthcare planning and policy development.

Ethnicity	2020	2021	2022
White - British	41886	50195	54259
White - Any Other Background	1386	1673	2020
Asian	225	374	527
Black	107	127	216
Chinese	55	49	53
Mixed	88	136	146
Other	362	590	849

Table 14: Cumberland Infirmary A/E attendance by Ethnicity (North Cumbria Integrated Care NHSFT)

Over the three-year period from 2020 to 2022, ethnic minority groups in Cumberland have demonstrated significant increases in their attendance at the Accident and Emergency (A&E) department. Among these, the Asian population has shown the most substantial growth, with attendances rising from 225 in 2020 to 527 in 2022—a 134% increase. This notable rise suggests a growing reliance on or improved access to emergency healthcare services within this community. Similarly, the Black population's attendance more than doubled, increasing from 107 in 2020 to 216 in 2022, representing a 102% growth. These figures highlight the increasing healthcare demands among these populations and emphasise the importance of targeted interventions to address their needs.

The category labelled "Other" ethnicities also saw a dramatic rise, with attendances climbing from 362 in 2020 to 849 in 2022—a 134% increase. This broad classification likely includes diverse communities whose specific health needs may require further investigation. In contrast, attendances among the Chinese population remained relatively stable, with only a slight decrease from 55 in 2020 to 53 in 2022. This stability may indicate consistent patterns of healthcare use or potential barriers preventing a similar growth in attendance as seen in other groups.

While the White - British group remains the majority in absolute numbers, with attendances growing from 41,886 in 2020 to 54,259 in 2022, their proportional growth was modest at 29%. This disparity in growth rates between majority and minority groups suggests that ethnic minorities are increasingly represented among A&E service users. The overall trends reflect a shifting demographic profile in Cumberland and highlight the need for healthcare services to adapt to a more diverse population.

Adult Social Care

Ethnicity	Number	% Total
White British	8462	83.83
Information Not yet Obtained	1269	12.57
White English	164	1.62
White European	69	0.68
Any Other White Background	30	0.3
Any Other Mixed Background	15	0.15
Any Other Asian Background	13	0.13
Any Other Ethnic Group	13	0.13
White Scottish	12	0.12
Black British	7	0.07
White Irish	7	0.07
Asian British	6	0.06
Arab	4	0.04
Chinese	4	0.04
Bangladeshi	3	0.03

Black African	2	0.02
Indian	2	0.02
Pakistani	2	0.02
White and Asian	2	0.02
White and Black African	2	0.02
White and Black Caribbean	2	0.02
Any other black Background	1	0.01
Black Caribbean	1	0.01
White Welsh	1	0.01
Refused	1	0.01
Total	10094	100.00%

Table 15: All Open Adult social care referrals in Cumberland (Cumberland Adult Social Care Service)

Usage by Ethnic Group

The majority of adult social care users in Cumberland identify as White British, representing 83.83% of all open referrals (8,462 cases). This is consistent with the historically high proportion of White British residents in Cumberland. Other White ethnicities, such as White English, White European, and White Irish, account for smaller percentages, collectively contributing approximately 2.37% of all referrals.

Among minority ethnic groups, Black British (0.07%), Asian British (0.06%), and Chinese (0.04%) have very low representation in service usage. Additionally, referrals for mixed ethnicities, such as White and Black Caribbean or White and Asian, each constitute only 0.02% of the total. The Information Not Yet Obtained category comprises a significant 12.57% of all referrals, reflecting a substantial gap in data collection that hinders a more accurate understanding of service utilisation patterns.

Proportionality of Usage Relative to Population Demographics

Comparing the service usage data to Cumberland's overall population demographics reveals potential disparities. While White British usage aligns proportionally with their demographic majority, the utilisation rates for ethnic minorities appear disproportionately low. For

example, Asian British, Black African, and Arab populations collectively account for only 0.12% of referrals, suggesting possible underrepresentation. This disparity may result from barriers such as lack of awareness about available services, cultural stigma around seeking care, or limited cultural competency within the service.

The ‘Information Not Yet Obtained’ category highlights the need for better data collection to understand the full extent of service utilisation. Without accurate ethnicity data, it is challenging to assess whether adult social care services are equitably addressing the needs of all communities.

GP records/ GP Out of Hours

A significant issue in addressing health inequities in Cumberland is the lack of ethnicity data collection by GP out-of-hours services, worsened by the reluctance of general practices to share even anonymised records. This gap in data recording presents a major barrier to understanding the specific needs and service utilisation patterns of different ethnic groups. Without this information, it becomes challenging to assess whether certain populations are disproportionately relying on out-of-hours care, experiencing barriers to accessing primary care, or facing other systemic inequities. The absence of shared ethnicity data not only limits the ability to identify and address health disparities but also undermines efforts to provide culturally competent care. Cumberland Council and health partners must prioritise the implementation of robust data collection systems and work with GPs to enable anonymised data sharing, ensuring ethnicity is routinely and accurately recorded. This improvement would provide vital insights to inform service planning and promote health equity across all communities.

Implications for Health and Social Care

These barriers and gaps present significant challenges but also opportunities for improvement:

- The overuse of emergency services highlights a need for stronger engagement with primary care and preventative health services.
- The underrepresentation of ethnic minorities in adult social care indicates systemic issues in awareness, accessibility, and cultural competency.
- The lack of robust ethnicity data impairs the ability to monitor disparities and evaluate interventions effectively.

Availability of Health and Support Services

Cumberland's ethnic minority populations benefit from a variety of health and support services tailored to meet their specific cultural and social needs. These services, offered by local charities, health organisations, and community groups, play a vital role in promoting health equity and fostering social inclusion.

Health and Wellbeing Services

The Cumberland Council provides a range of health and wellbeing services that are accessible to all residents, including ethnic minorities. These services include advice on mental health, substance abuse, and preventative health measures, ensuring culturally sensitive approaches to healthcare (Cumberland Council, 2024). The council's Healthy Start Scheme further supports families by offering nutritional advice and assistance.

Healthwatch Cumberland acts as an independent voice for residents, advocating for improved health and social care services. By gathering feedback from ethnic minority communities, the organisation ensures that these groups are represented in decisions about local health service improvements (Healthwatch Cumberland, 2024).

Mental Health Support

Mental health services specifically designed for ethnic minority communities are available through organisations such as BAME Hub-UK Network and Mind. These organisations provide culturally sensitive mental health support, ensuring that cultural stigmas around mental health do not prevent individuals from seeking help (BAME Hub-UK Network, 2024), (Mind, 2024). Advocacy Focus further aids individuals by navigating health and social care systems and ensuring equitable access to services (Advocacy Focus, 2024).

Charities and Community Groups

Multicultural Cumbria is a cornerstone organisation in the region, focusing on integration, education, and cultural celebration. They provide support for ethnic minority residents, including help with accessing healthcare, language support, and organising cultural awareness events. These initiatives not only enhance community cohesion but also improve access to critical services (Multicultural Cumbria, 2024).

BHA for Equality addresses health disparities by focusing on areas such as HIV and sexual health, mental health, and community health education. Their tailored approach ensures that ethnic minority groups receive support that is both culturally and linguistically appropriate (BHA for Equality, 2024).

Advocacy and Education

Organisations like Healtogether CIC empower individuals from minority communities by providing mental health education and support services. Their community-based approach helps reduce stigma and build resilience within these groups (Healtogether CIC, 2024). Additionally, Multicultural Cumbria's youth programmes equip young people with leadership skills, fostering a sense of belonging and empowerment (Multicultural Cumbria, 2024).

Cumberland's diverse range of health and support services demonstrates a commitment to meeting the needs of its ethnic minority populations. Collaborative efforts between local councils, charities, and community organisations ensure that these communities have access to culturally appropriate and equitable services, addressing health disparities and fostering inclusion.

Stakeholder and Community Input

To complement the quantitative data and findings from the literature, a qualitative investigation was undertaken to explore the perspectives and experiences of ethnic minority communities in Cumberland. This investigation included interviews with community leaders and prominent individuals who have extensive experience working with these populations, these included individuals from Cumberland council, Cumbria fire and rescue service, Multi-cultural Cumbria and other local organisations. This section looks at insights from local community leaders and ethnic minority residents, alongside evidence from national research, to provide a comprehensive analysis of the barriers faced by ethnic minorities in accessing health and social care services. These findings underpin actionable recommendations for developing equitable and inclusive systems.

Please see 'methodology' section for information about the structure and format of the interviews and focus groups.

Key Issues Identified by Community Leaders

Interviews with community leaders in Cumberland reveal systemic barriers disproportionately affecting ethnic minority populations. While there were many views and concerns shared by the people interviewed, there were a few common themes that emerged.

1. **Healthcare Access and Communication**:

    - Community leaders noted significant challenges in accessing GP and dental services. Capacity issues have left ethnic minorities underserved, with many relying on A&E as a fallback option. This aligns with the regional findings

presented above that indicate higher emergency care usage among ethnic minorities due to difficulty accessing primary care.

- Language barriers remain a critical issue. Many healthcare settings lack adequate access to professional interpreters, leaving children or relatives to interpret, which compromises care quality.

2. **Mental Health Stigma and Service Gaps**:

   - Stigma around mental health was cited as a pervasive issue, particularly in South Asian, Arab, and African communities. Leaders reported a lack of culturally sensitive mental health services, which discourages engagement and perpetuates untreated mental health conditions, they also felt some communities had a negative attitude towards mental health which is underpinned by cultural beliefs. To improve engagement, more needs to be done about changing these beliefs.

3. **Social and Cultural Determinants of Health**:

   - Some community leaders highlighted common health issues, such as vitamin D deficiency, hypertension, and diabetes, as being poorly managed compared to the White population. These conditions often require tailored interventions, yet most services remain generalised.
   - Leaders emphasised the impact of hate crimes on mental health. Victims often rely on community support rather than formal systems, which are perceived as inaccessible or unsympathetic. They felt more work needed to

be done by emergency services, especially police and fire services to help break down barriers and improve community engagement.

4. **Trust in Services**:

    - A lack of trust in healthcare providers was frequently cited. Instances of dismissiveness or condescension from practitioners have led to disengagement from essential health services.

Perspectives from Ethnic Minority Residents

Focus groups and interviews with Cumberland's ethnic minority residents provide detailed accounts of the issues they feel they are facing regarding their health and access to services:

1. **Language and Interpretation**:

    - Residents reported consistent difficulties in obtaining interpreters for appointments. When interpreters were available, many were untrained in medical terminology, leading to miscommunication and inadequate care. This echoed the opinions of community leaders, and it was one of the most highlighted issues facing minority populations in Cumberland.

    - Automated systems for booking GP appointments, available only in English, were a source of frustration for non-native speakers. Many residents had grievances with their registered GP for not offering alternative methods for booking appointments, many residents felt they were unable to book appointments due to language barriers. This consequently led many people to avoid booking appointments.

2. **Insensitivity from health care providers**

- A prominent concern expressed by the ethnic minority communities consulted was an ingrained belief that they were not valued equally by healthcare providers. Many individuals felt that their concerns were frequently dismissed or ignored, and they perceived that healthcare staff were less attentive and gave them less time compared to other patients. This lack of care and attentiveness left many feeling that the healthcare system did not prioritise their needs. While a significant number of individuals attributed this treatment to racial bias, others believed it stemmed from systemic issues such as understaffing and overstretched services. These perceptions, whether rooted in discrimination, resource limitations, or both, highlight a critical barrier to building trust between healthcare providers and ethnic minority communities.

3. **Mental Health Stigma**:

    - Mental health remains a taboo topic in many ethnic minority communities. Residents reported avoiding mental health services due to cultural norms and fear of judgment. This point was echoed by community leaders, and it is supported in the national data when looking at ethnic minority mental health service engagement.

4. **Dental and Preventative Care**:

    - Dissatisfaction with dental services was universal among participants, with many citing long waiting times and limited NHS capacity. This was a major complaint from most of the communities and people that I spoke to, when asking people their opinions on how to improve their health/healthcare, on

the most common answers was increased access to dental services for them and their children.

5. **Cultural and Systemic Barriers**:

    - Many residents expressed confusion about navigating the UK healthcare system, particularly around follow-up appointments and referrals. This has been supported by regional data. There were a lot of questions asking where they could go to access guidance on how to access different services.
    - Cultural expectations of care, such as a preference for a paternalistic approach, often clash with the patient autonomy model of UK healthcare, leading to dissatisfaction and disengagement.

Analysis and Interpretation of Findings

The findings from this Health Needs Assessment (HNA) illuminate critical challenges and opportunities related to the health and social care needs of ethnic minority populations in Cumberland. These insights, derived from both quantitative data and qualitative feedback, highlight disparities in health outcomes, service utilisation, and barriers to care.

Key Themes from the Findings

1. **Demographic and Geographic Disparities**

   Cumberland's ethnic minority population has grown significantly in recent years, with Carlisle hosting the highest concentration of these communities. While this urban clustering provides opportunities for targeted service provision, rural areas with dispersed ethnic minority populations may experience heightened challenges in accessing equitable services. The growth from 1.53% to 2.33% between 2011 and 2021 highlights an increasing demand for culturally and linguistically tailored services.

2. **Health Outcomes and Service Utilisation**

   Ethnic minorities in Cumberland face a disproportionate burden of chronic conditions such as diabetes and cardiovascular diseases, mirroring national trends. Mental health concerns, compounded by cultural stigma, remain underreported and under-addressed within these communities. Additionally, there is evidence of over-reliance on emergency services due to barriers in accessing primary and preventive care, which exacerbates health inequalities.

3. **Barriers to Accessing Services**

- **Language Barriers**: Non-native English speakers struggle with healthcare systems designed primarily for English-speaking users. This includes difficulties booking appointments, communicating with providers, and understanding treatment plans.
- **Trust and Perception of Care**: A notable portion of ethnic minority residents perceive health services as unwelcoming or dismissive of their needs. These feelings, compounded by cultural differences and systemic pressures, reduce engagement and trust in health systems.
- **Navigation of the System**: Many residents expressed confusion about referral pathways and follow-up care, highlighting a need for clearer guidance and support for navigating services.

4. **Cultural and Systemic Factors**

   Stigma around mental health and a preference for culturally specific care models are prominent barriers. National and local data suggest that these barriers contribute to reduced engagement with available services, leading to unmet health needs. Community leaders also emphasised the role of systemic issues, such as capacity constraints and insufficient cultural competency training among health and social care staff.

Implications of the Findings

1. **Service Accessibility and Equity**

   Addressing inequities requires a dual focus on increasing physical and linguistic accessibility. The lack of interpreter services and multilingual outreach is a recurring

issue that contributes to service underutilisation and poorer health outcomes among ethnic minorities. This aligns with the need for targeted investment in language support services.

2. **Health Promotion and Preventive Care**

   The higher prevalence of chronic conditions within ethnic minority populations underscores the importance of culturally sensitive preventive health initiatives. Tailored interventions addressing dietary education, physical activity promotion, and early screening programmes are essential for reducing these disparities.

3. **Community Engagement and Trust-Building**

   Both qualitative and quantitative data emphasise the importance of building trust between healthcare providers and ethnic minority communities. Community-led solutions, such as involving ethnic minority leaders in the design and delivery of health services, could bridge existing gaps in trust and communication.

4. **Systemic Data Gaps**

   The lack of comprehensive ethnicity data from key services, such as GP out-of-hours care, presents a significant barrier to understanding and addressing health disparities. Improved data collection and reporting systems are essential for identifying trends, monitoring progress, and tailoring interventions.

5. **Integration of Services**

   The concentration of ethnic minority populations in urban centres like Carlisle provides opportunities for integrated service hubs that can offer tailored, culturally competent care. Conversely, outreach strategies must address the challenges of engaging dispersed populations in rural areas.

Recommendations

The following recommendations have been categorised into Core and Supporting areas based on their potential to reduce health disparities, improve service accessibility, and enhance health equity for ethnic minority communities in Cumberland. Core recommendations focus on structural and systemic changes that address fundamental barriers, such as language accessibility, ethnicity data collection, and service redesign, which will have a long-lasting and transformative impact on healthcare provision. Supporting recommendations, while equally valuable, focus on incremental improvements, such as awareness initiatives, digital access support, and staff training, which enhance patient experience and engagement but may not significantly alter service accessibility on their own. Prioritising core changes will establish a strong foundation for health equity, while supporting actions will reinforce these efforts and further improve engagement and service utilisation over time.

Core Recommendations

1. Improve Communication & Information Access

Language barriers and limited awareness of health services hinder engagement among ethnic minority communities. We recommend making multilingual resources a standard across all NHS and social care settings. This includes translating key patient-facing materials, digital platforms, appointment systems, and health information into multiple languages. Policies should mandate that healthcare communication is inclusive and accessible to diverse populations.

2. Expand Interpretation Services

The limited availability of interpreters continues to undermine patient experiences and

clinical outcomes. Expanding access to professional interpretation, across both in-person and digital platforms, is essential. Services should include on-demand phone and video interpreting, a larger pool of trained interpreters, and integration of translation tools into digital health systems.

3. Require Ethnicity Data Collection Across All Services

Inconsistent collection of ethnicity data restricts the ability to identify health disparities and develop equitable interventions. We recommend mandatory, standardised collection of ethnicity data in all health and social care settings, including primary care, urgent care, and community services. High-quality data is essential to understanding trends, tailoring interventions, and monitoring progress on health inequalities.

4. Increase Access to Preventive Care

Preventive services such as screenings, vaccinations, and early interventions are underutilised in many ethnic minority groups. Improving access involves targeted outreach campaigns, culturally tailored education, and community-based programmes. Preventive care must be actively promoted in a way that resonates with different cultural communities to reduce long-term health inequalities.

5. Adopt Patient-Centred Approaches

Building culturally competent, respectful, and inclusive care pathways is key to improving trust and engagement. Services should be co-designed with communities to reflect cultural preferences, values, and lived experiences. Healthcare providers must be trained in cultural humility, and services should consider the social determinants of health in every patient interaction.

Supporting Recommendations

1. Implement Multi-Lingual Booking Systems

Booking and navigating appointments remain a major barrier for non-English speakers. We recommend the rollout of multilingual telephone and online booking platforms that allow patients to choose their preferred language from the outset. This will improve access, reduce missed appointments, and support continuity of care.

2. Provide Digital Access Support

A lack of digital access and digital literacy prevents some patients from using translation apps or engaging with digital health services. We recommend providing free Wi-Fi in GP practices and community health settings, alongside offering support for using translation tools and accessing health information online.

3. Strengthen Community Engagement

Working in partnership with local multicultural and community organisations is vital for building trust and improving service uptake. We recommend co-developing outreach programmes, holding community health awareness events, and creating feedback channels that amplify the voices of ethnic minority populations.

Conclusion

The findings from this health needs assessment underscore the pressing need to address health inequities experienced by ethnic minority populations in Cumberland. While these communities represent a growing proportion of the local population, they face significant barriers in accessing and utilising healthcare and social care services. Key challenges include language barriers, limited cultural competence in service delivery, inadequate interpreter availability, and underrepresentation in preventive and routine care services.

The recommendations outlined in this report provide a comprehensive roadmap for Cumberland Council to enhance healthcare accessibility, improve patient experiences, and foster equity. By implementing measures such as better communication systems, expanded interpreter services, tailored community engagement, and enhanced data collection, the Council can ensure that the diverse needs of ethnic minority communities are met. These steps will also strengthen trust and collaboration between healthcare providers and communities, paving the way for improved health outcomes.

Strategic investment in both urban and rural areas, with a focus on culturally competent care, inclusive appointment systems, and preventive health programmes, will be critical in addressing disparities and ensuring equitable resource distribution. These actions align with Cumberland Council's broader goals of creating an inclusive, responsive healthcare system that values and supports all residents.

Moving forward, it is vital to continually assess and adapt these strategies considering demographic shifts and emerging needs. By fostering collaboration between local government, healthcare providers, and community leaders, Cumberland Council can not only address current gaps but also proactively build a healthier, more cohesive community

for the future. This commitment to equity and inclusion will not only benefit ethnic minority populations but also strengthen the overall health and well-being of Cumberland's diverse society.

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Appendix

Health Needs Assessment Focus Group Template

Introduction

- Welcome participants.
- Introduce yourself and any co-facilitators.
- Explain the purpose of the focus group: to gather insights on the health needs and challenges faced by the Afghan community in Cumberland.

Confidentiality and Consent:

- Reiterate the confidentiality of the discussion and assure participants that their responses will be anonymised.
- Obtain consent for recording the session for accurate transcription and analysis. Reinforce their right to withdraw at any time.

Icebreaker

- Ask participants to introduce themselves briefly.
- Pose a general question to warm up the group, such as: "Could each of you share a bit about your experiences living in Cumberland as a member of your community?"

Understanding Health Perceptions

- What does good health mean to you and your community?

- How do you think your community perceives health and well-being?

- Are there any traditional practices or beliefs related to health within your community?

Identifying Health Challenges

- What are the main health challenges faced by your community in Cumberland?

- Are there any specific health issues that you or members of your community frequently encounter?

- How accessible are healthcare services for your community in Cumberland?

Are there any barriers to accessing healthcare?

- Do you notice any health issues that seem to be more prevalent or significant among Your community in Cumberland compared to other groups?

Healthcare Utilisation

- How often do members of your community in Cumberland seek medical care?

- What factors influence your decision to seek healthcare services

- Have you or members of your community encountered any difficulties in navigating the healthcare system?

Cultural and Linguistic Considerations

- How do cultural beliefs and practices impact health behaviours within your community in Cumberland?

- Are there any cultural or language barriers that hinder Your community from accessing or engaging with healthcare services in this region?

- What strategies do you think could help overcome these cultural and language barriers?

Mental Health and Wellbeing:

- How is mental health perceived within your community in Cumberland?

- Have you observed any specific mental health challenges experienced by Your community in this region?

- Are the existing mental health support services in Cumberland adequate for you/ your community, and if not, what improvements are needed?

Community Resources and Support

- What community resources or support networks exist for your community in Cumberland regarding health and well-being?
- Are there any initiatives or organisations that have been particularly helpful in addressing health needs within your community?
- How effective do you find these support networks, and what enhancements could be made?

- Are there any gaps in support services that should be addressed to better meet the needs of the Syrian community in Cumberland?

Suggestions for Improvement

- Do you feel as though Covid – 19 has impacted your experience of healthcare in anyway? Can you explain further?

- Based on your experiences and insights, what do you think could be done to improve the health and well-being of the Afghan community in Cumberland?

Closing

- Thank participants for their valuable contributions.
- Let them know how their input will be used to inform public health efforts in Cumberland.

Optional: Additional Comments

Does anyone have any further/final comments that maybe haven't been discussed already?