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**Irish
in Britain**

Degrees of Ethnic Inclusion Revisited

Analysing Irish inclusion in JSNAs

April 2014

Robert Walsh

With additional contributions by

Charlotte Curran, Seán Hutton, and Mary Tilki

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Executive Summary

According to the NHS Confederation “The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities”.¹ JSNAs are critical to local government and service providing organizations in knowing where to focus their efforts and resources in order to improve health and wellbeing. If certain groups are excluded from these assessments they will miss out on important attention and subsequently the aid they need.

This is a report of a survey of JSNAs which began in 2012 and which was followed up in 2013. It invited 52 JSNA leads across nine regions of England to identify the extent to which they took account of their Irish populations and liaised with local Irish third sector organisations when assessing health needs. The JSNAs were selected because of their proximity to one or more Irish third sector organizations.

Following the publication of *Degrees of Ethnic Inclusion* (2012) Irish in Britain wrote to all JSNA leads providing them with the address and contact details of their local Irish service requesting that they engage with them to ensure Irish health inclusion in the next JSNA. In addition we provided various fact sheets relating to Irish health and the Health Supplement, Cancer and the Irish Community (FIS/NCAT 2011).

The purpose of the most recent survey is to follow up *Degrees of Ethnic Inclusion* (2012) and that involved 29 of the 52 JSNAs previously investigated. For various reasons it was only possible to identify 29 leads in the 52 areas. The questionnaire inquired whether or not they had been in contact with local Irish community organizations, when the latest JSNA was published, when the next would be published and the names of the designated contact for JSNAs and Local Healthwatch. Of the 29 localities contacted, only 8 responded with different degrees of depth in answering the questions.

The most positive response was from the Greenwich JSNA lead:

The Greenwich Public Health & Well-Being Directorate... have had on-going contact over many years with the local community organisation / service provider known as Irish Community Services... The organisation is regarded as one of our key local partners, and as such is routinely invited to participate in various consultations with the aim of helping us to engage with and disseminate information to the Irish community in Greenwich.

However, this was one of our better responses and at the other end of the spectrum we received answers as brief as “No.”. Other responses included comments on why they had or had not included their local Irish communities in the construction of their JSNAs. Some of these explanations cited the changing public health system, staff reduction, lack of staff, working with all community organizations in their areas including Irish groups.

¹ "The Joint Strategic Needs Assessment." [online] Available at: <http://www.nhsconfed.org/Publications/briefings/Pages/joint-strategic-needs-assessment.aspx>

NB It is worth noting that since the *original report*, not all of the JSNAs have been updated. 15 of the 52 JSNAs are the same documents (which are accessible on line) used in the previous study and therefore yield the same results for those areas. Clearly infrequent updating of JSNAs is a problem in itself and given the limited inclusion of the Irish in the last report and the lack of response this year, there is sufficient concern to aggregate responses from both years.

Findings: Local Population Demographics

- Of the total 52 JSNAs observed, 25 included a White Irish or Irish category in their demographics section, while 27 did not.
- Of the total 52 JSNAs observed, 35 have at least one mention of White Irish or Irish throughout the entirety of the JSNA, while 17 did not.
- Of the total 52 JSNAs observed, 26 have at least one mention of Irish Traveller or GRT (Gypsy, Romani, and Traveller) throughout the entirety of the JSNA, while 26 did not.
- All 52 of the JSNAs included either White or White British and BME categories in their analysis.

Since the last report the number of times the Irish are mentioned has dropped from 82% to 67%. This is particularly concerning given the perfect score of 100% of BME inclusion for both analyses. The number of times Irish Traveller and GRT are mentioned have grown from 37% to 50%. This is a positive improvement that will hopefully carry on into the future.

Breaking the data down by regions, the Yorkshire & Humberside, North West, South East and London areas were most likely to mention the Irish. The lowest occurrence by was in the North East region which reflects the fact that there is only have partner organization and as such one JSNA from that region.

The lowest percentage of JSNAs to mention the Irish was in the East Midlands at only 33%. Irish Traveller and GRT were more frequently mentioned in the South East where a significant number of Irish Travellers located.

Irish were mentioned in all 9 regions while Irish Travellers and GRT were mentioned in 8, the North East being the exception.

Findings: Local Health Demographics

Replicating the previous report, a selection of keywords which represent health concerns that commonly affect the Irish community were chosen. These keywords included: Dementia, Cancer, Cardiovascular, Mental Health, Haemochromatosis, Smoking, and Alcohol. This was done to examine the level in which the localities were observing and reporting on these health concerns in relation to the Irish population. With the exception of Haemochromatosis, these conditions or health issues are identified as key issues in all JSNAs

The number of JSNAs mentioning specific health issues for the Irish are as follows:

- Dementia or Haemochromatosis 0
- Cancer 2 (1 in South East and 1 in Yorkshire & Humberside)
- Cardiovascular Disease 6 (2 in South East and 1 in London, North West, West Midlands, and Yorkshire & Humberside)
- Mental Health 8 (2 in London, South East, and Yorkshire & Humberside and 1 in East of England and West Midlands)
- Smoking 11 (4 in London, 3 in South East, 2 in Yorkshire & Humberside, and 1 in East of England and West Midlands)
- Alcohol 9 (3 in London, 2 in South East, and 1 in East of England, North West, South West, and Yorkshire & Humberside)

While the numbers acknowledging cancer and cardiovascular disease has increased, the recognition of smoking as a health issue among the Irish has decreased by three. The decline could be due to a drop of occurrence in smoking among the general population although rates of decline are slower among Irish people. The JSNAs that did include the Irish in their section on smoking acknowledged that Irish males had one of the highest smoking rates of all ethnicities. It is possible that the localities are taking action in solving these issues, but focusing on the general population, rather than on certain ethnic groups where related health concerns may be higher.

The findings of this survey have tracked the inclusion (or otherwise) of Irish people living in JSNA jurisdictions in England. This evidence will enable Irish in Britain identify where to focus our efforts in ensuring local communities are not excluded in interventions to address inequalities and improve health. Tracking health demographics will help identify good practice, but importantly it will enable us to engage with JSNAs and Local Healthwatch who discriminate against local Irish communities. We have repeated the process of providing information to all local JSNA leads as well as the recently established Local Healthwatch bodies and will follow up next year and will invoke Freedom of Information legislation as necessary.

Conclusions

JSNAs generally recognise the existence of local Irish populations, but are largely failing in their duty to acknowledge the health disadvantage experienced by this community or to take account of their needs. This has deteriorated since the last survey.

Despite being provided with relevant and specific health concerns common to the Irish community and details of local Irish organisations, JSNAs are failing in their duty to consult with local Irish organisations working with local populations.

It is encouraging that more attention is being paid to GRT communities, particularly Irish Travellers.

Given the older age profile of the Irish population, the highest mortality rates from cancers, among the highest rates of cardiovascular disease and persistently elevated levels of mental ill-health and a growing incidence of dementia, JSNAs, Healthwatch and Health and Well Being are failing in their equality and diversity duties.

Recommendations

The recommendations for this report are that:

- 1) JSNAs must include the Irish in their demographic data analysis in order to track the growth or decline and the level of need of Irish populations.
- 2) JSNA bodies must consult and collaborate with local Irish third sector organizations to understand the specific needs of the Irish community and plan to address them.
- 3) JSNAs must take account of the social determinants of health and specific needs of the Irish community as part of their BME strategy.
- 4) JSNA publishing bodies should continue to improve their tracking and work with Irish Traveller communities to address their unique health needs.
- 5) That all Local authorities and services, as good practice, should be using the Census 2011 categorisation in relation to ethnicity.

Background and Rationale

What is the JSNA?

The Joint Strategic Needs Assessment (JSNA) is “*systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve health and wellbeing outcomes and reduce inequalities* (DH 2007). JSNAs are a statutory duty imposed by the Local Government and Public Involvement in Health Act (2007). They provide a significant opportunity for reformed local partnerships to ensure healthcare and wellbeing services are responsive to community need and meet equalities obligations enshrined in law.

Tackling persistent health inequalities requires the collaboration of public health, health services and local government as well as other public sector partners, businesses and the community and voluntary (third) sector. JSNAs enable local areas to identify need, commission services and engage communities in improving health and wellbeing. The JSNA process involves identifying the current and future health and well-being needs of the local population it is representing. It should take account of population number and composition, ethnicity, age and gender. In particular it should consider the social determinants of health as well as particular health issues and lifestyle factors while at the same time engaging communities in improving health and wellbeing. They are not an end in themselves but an ongoing process of strategic assessment, planning and developing evidence based services to improve health and reduce inequalities.

JSNAs rely on a range of quantitative and qualitative data, community and user views and this information should inform the Joint Health and Wellbeing Strategy (JHWS) produced by the Health and Wellbeing Board which will drive local strategic commissioning (Shared Intelligence /Race for Health 2010). There is an equal and joint statutory duty on Local Authorities and Clinical Commissioning Groups to produce JSNAs and JHWS through the Health and Well Being Boards which drive the commissioning of primary and secondary care. The NHS Commissioning Board must participate in JSNAs and JHWS and must take account of them when commissioning services. Public Health England supports local authorities in delivering appropriate local interventions (DH 2013)

The content of the JSNA is drawn from a range of data including the census data and any information provided from partnerships with a range of statutory and non-statutory bodies. Examples of these include:

- Public Health data
- Views collected by local Healthwatch
- Input from voluntary and community organisations
- Feedback to local providers from service users/ outcome evaluations
- Information from social care staff, GPs, community nurses etc.
- Views from community consultation/ participation

The statutory guidance on JSNA and JHWS (DH 2013) points out that where there is a lack of evidence on certain health issues or seldom heard groups, this could indicate unmet need. Partnerships with local third sector can not only help engage such groups but can support active communities in improving their own health and wellbeing and enhancing social cohesion.

Rationale

The content of the JSNA (and JHWS) is of vital importance in improving health and wellbeing and addressing health inequalities. JSNAs in general are still at the development stage and only just beginning to address ethnic health inequalities (LGID undated). There is thus considerable scope to include the Irish community, usually invisible in inequalities debates because of being aggregated into a homogenised White category. The health and socio-economic profile of the Irish is more akin to that of visible BME communities than the White British population.

There is clear evidence of the highest rates of mortality from cancer, some of the highest death rates from heart disease and stroke with this pattern of disadvantage persisting into the third generation. Limiting long term conditions are high across all age groups and lead to early exit from the labour market with all the problems that ensue from unemployment. There are high rates of common mental disorders, older age admissions to mental health establishments and persistently high levels of suicide. The older age profile of the Irish population in Britain compared to the general population and other minority ethnic groups, is inevitably accompanied by problems of (mostly preventable) ill-health and there is a growing incidence of dementia. Mortality rates and morbidity levels are significantly worse for Irish Travellers across a range of health issues. The poor socio-economic circumstances of sections of the Irish community who disproportionately live in areas of marked multiple deprivation, confounds their access to health and social care in an equitable or timely manner. Smoking is declining but slower than in the population as a whole and although there are high levels of abstinence, dangerous patterns of alcohol consumption persist in sections of the community.

The purpose of the Degrees of Ethnic Inclusion Report is intended to raise awareness of the importance of including an Irish dimension, not just in the demographic section but in the identification of common health issues. The omission of Irish from JSNAs, excludes the community from JHWS and loses the focus on prevention, commissioning of culturally sensitive services (where needed) and reduces opportunities to reduce inequalities. Health inequalities among the Irish in Britain (like other BME groups) are not confined to race/ethnicity but combine with age, gender, physical or psychological disability and more broadly to deprivation and disadvantage. Therefore, highlighting the non-inclusion of the Irish in a range of JSNAs in this report will allow Irish in Britain and local Irish organisations to advocate on behalf of the community at local level. It will also provide JSNAs with opportunities for evidence not easily available, link them with communities and allow relevant authorities to work with the community to build social capital and improve their own health. It can highlight the potential for partnerships, commissioning services and the development of culturally responsive strategies which people deserve.

Methodology:

A survey was undertaken using an explanatory letter with five brief questions to be answered emailed to 52 JSNA leads identified through their relevant websites.

Because of various NHS and Social Services reforms, restructuring and changes in roles and responsibilities, it proved impossible to contact leads in all 52 JSNA areas. Despite numerous emails and phone calls it was only possible to identify 29 leads in the 52 areas.

The questions were:

- Whether the person was the appropriate contact regarding Irish inclusion in JSNA
- Whether contact had been made with Irish organisations/service providers on the basis of the information provided by FIS (now Irish in Britain)
- When the last consultation with local communities happened and the consequent JSNA published
- When the next JSNA process would be initiated
- Name and contact details for the designated contact for local Healthwatch

Online JSNAs from the same 52 JSNA authorities were then analysed. As in the previous survey JSNAs were chosen based on their proximity to third sector Irish services who are members of Irish in Britain. We endeavoured to include JSNAs in each of the nine governmental regions.

- East Midlands
- East of England
- London
- North East
- North West
- South East
- South West
- West Midlands
- Yorkshire & Humberside

The online JSNA documents were analysed to examine whether they:

- Identified Irish as a separate ethnic group in the demographics section of the JSNA
- Identified Irish as a subcategory of White, White Other or BME
- Included Irish under specific health/lifestyle categories
- Included Gypsies, Romani, and Irish Travellers (GRT) throughout the JSNA
- Included Black (Asian) and Minority Ethnic (BME or BAME groups throughout the JSNA

Having examined the demographic elements, the JSNA documents were searched for any mention of Irish or Gypsy, Romani, Traveller in relation to the following conditions /health issues of key concern for the Irish community in England:

- Dementia
- Cancer
- Cardiovascular disease
- Mental Health
- Haemochromatosis
- Smoking
- Alcohol

Analysis and Conclusions:

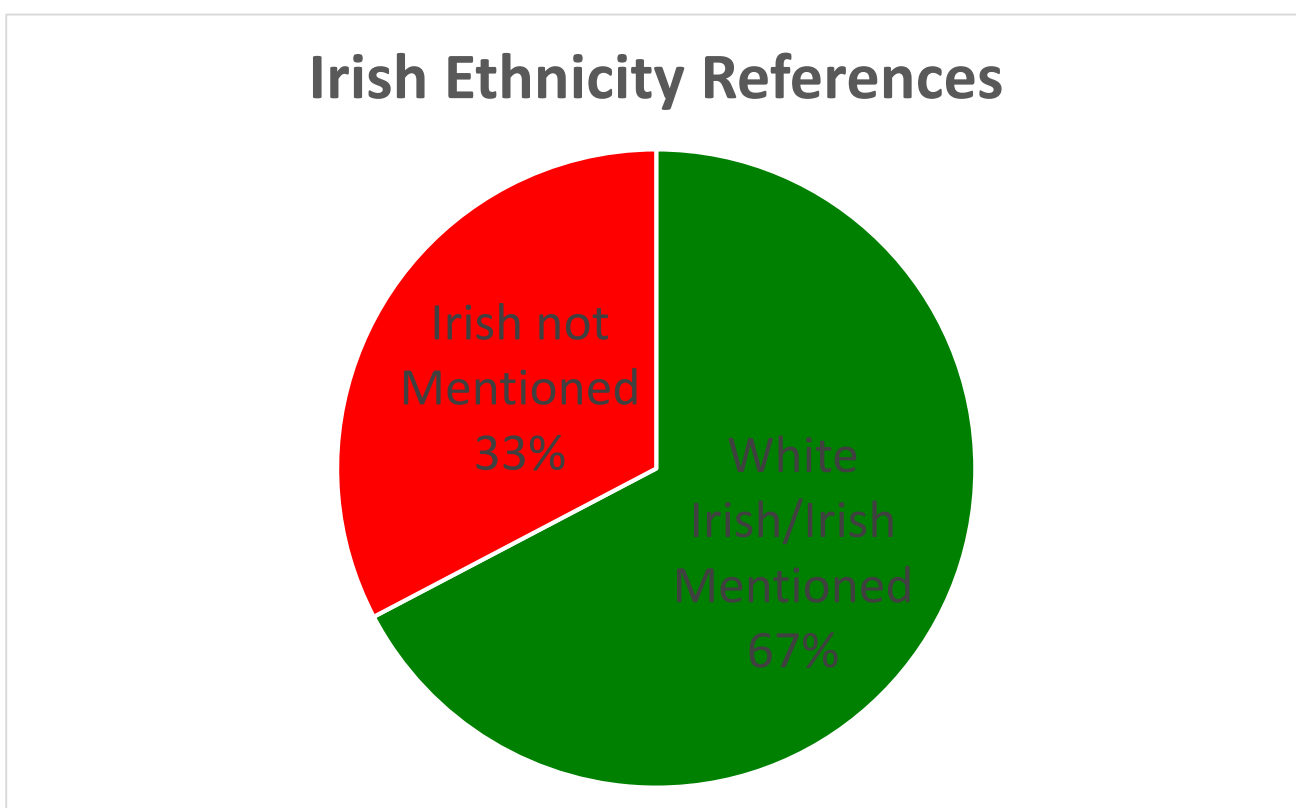
Phase 1: Population Demographics

Irish Inclusion in Full JSNA

The first variable we measured was the number of times Irish or White Irish were mentioned throughout the entire JSNA, both in demographics and in the general text. The results for the findings are as follows:

Irish Mentioned	Irish Not Mentioned	Total
35	12	52

Table 1



Graph 1

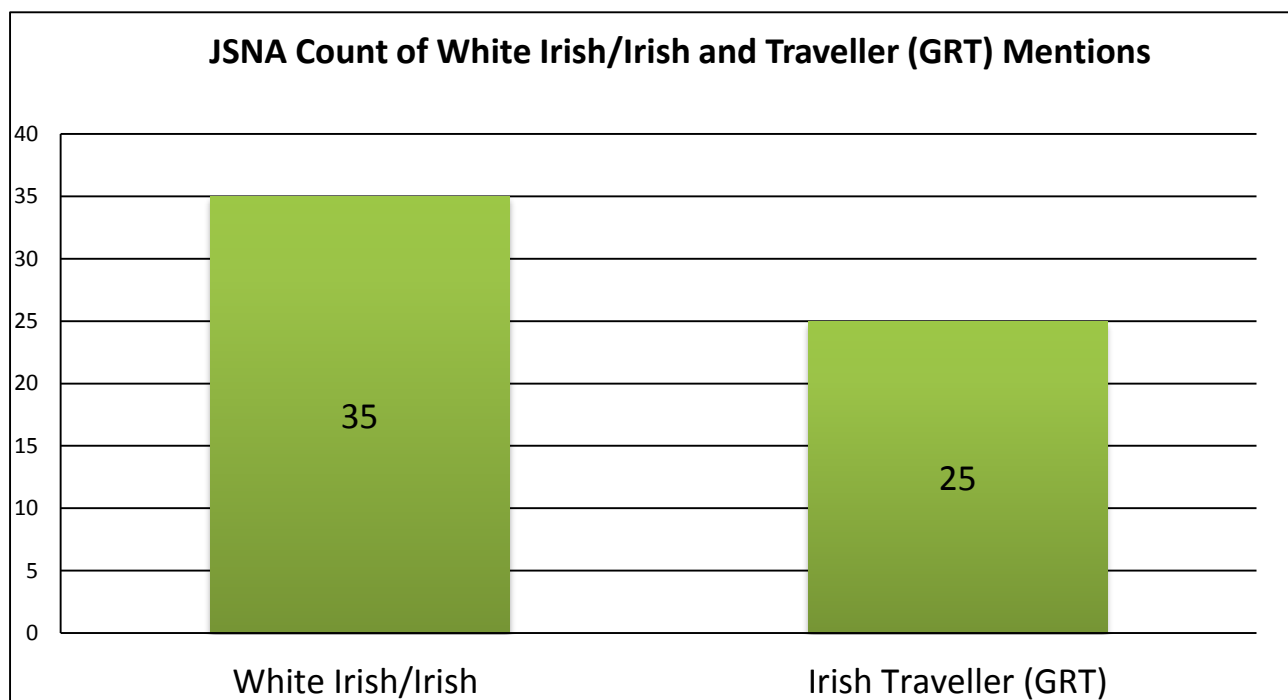
Graph 1 shows us that one third of the 52 JSNAs that were inspected did not include Irish or White Irish anywhere in their publication. This is a decrease of 15% since the last study was conducted.

Irish Traveller (GRT) Inclusion in Full JSNA

We also examined the change in Irish Traveller mentions in the entirety of the JSNAs. Like the general Irish population, Irish Travellers also have very specific health needs that should be well recognized.

Group	Irish	Irish Traveller
Count	35	25

Table 2



Graph 2

Irish Travellers:

Compared to the general population Irish Travellers generally have poorer health and a higher rate of morbidity and premature mortality. This highlights the drastic need for GRT communities to be recognised by local health organizations as a distinct group with particular health needs related to the social context of their ways of life. In a report published by the Traveller Movement (formerly Irish Traveller Movement in Britain) they stated:

“local authorities establishing Health and Wellbeing Boards need to ensure that Gypsies and Travellers are included as key stakeholders. These boards will be relying on comprehensive Joint Strategic Needs Assessment (JSNA’s) to inform their work. It is therefore critical that vigorous local Gypsy Traveller health assessments are conducted and that every effort is made to engage these communities in this process”²

There has been an increase in the number of times Irish Travellers have been mentioned in the JSNAs. While this is encouraging there is considerable scope for improvement both in recognising GRT communities in demographic data and in identifying how their specific health needs will be addressed.

² Irish Traveller Movement in Britain. *The Health and Wellbeing of Gypsies and Travellers*.

Irish Inclusion in Demographics Section

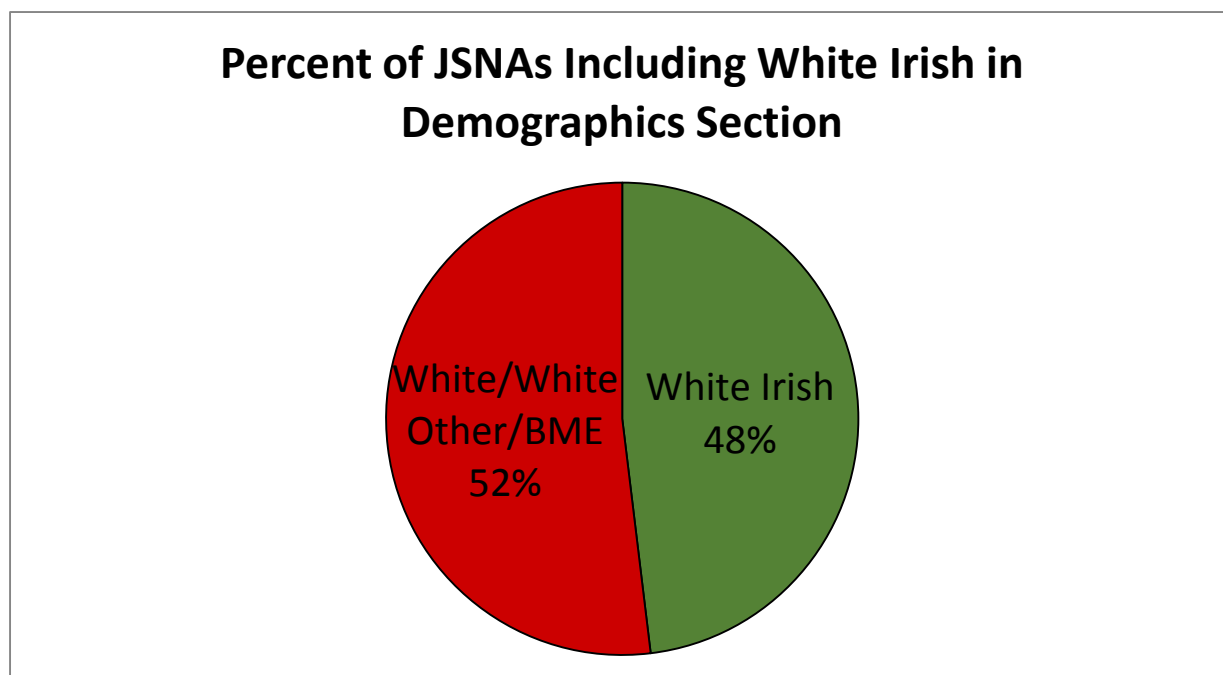
At this point we focused our attention specifically on the demographic section of the JSNAs. Our goal was to document if the JSNA included a White Irish category within the demographic tables and text or if the Irish ethnicity category was submerged in a White, White Other, or BME category. The results are as follows:

White Irish	White/White Other/BME	Total
25	27	52

Table 3

We found that 25 out of the total 52 JSNAs have White Irish or Irish as a distinct group in their demographics section. This is compared to 27 JSNAs where the Irish were included in the White Other, BME, or all-encompassing White category.

Compared to the previous study this is a large decrease in the number of times White Irish were mentioned as a distinct ethnic group in the demographic sections of JSNAs. The previous *Degrees of Ethnic Inclusion* (2012) showed 32 JSNAs with distinct White Irish categories, 19 were aggregated in overall White group, and 1 which had no specific Irish demographic data. This highlights a 13% decrease in the identification of a specific White Irish category and a 15% increase in aggregating Irish in overall White or White Other categories over the previous 2 years.



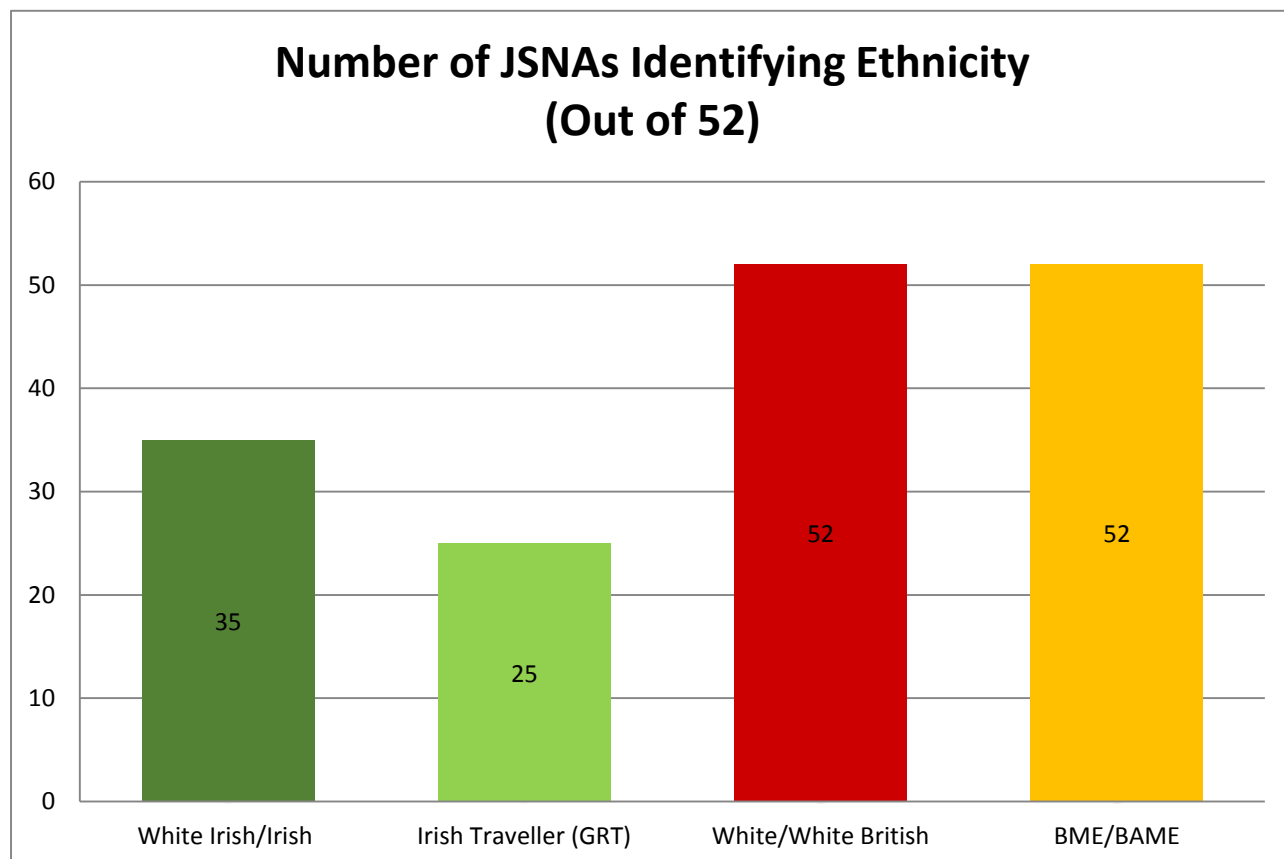
Graph 3

Inclusion Summary

Summing up the data on references to ethnicities in this Phase 1, Table 4 and Graph 4 show the frequency of JSNAs where the target groups were mentioned.

White Irish/Irish	Irish Traveller (GRT)	White/White British	BME/BAME
35	26	52	52

Table 4



Graph 4

Inclusion by Region

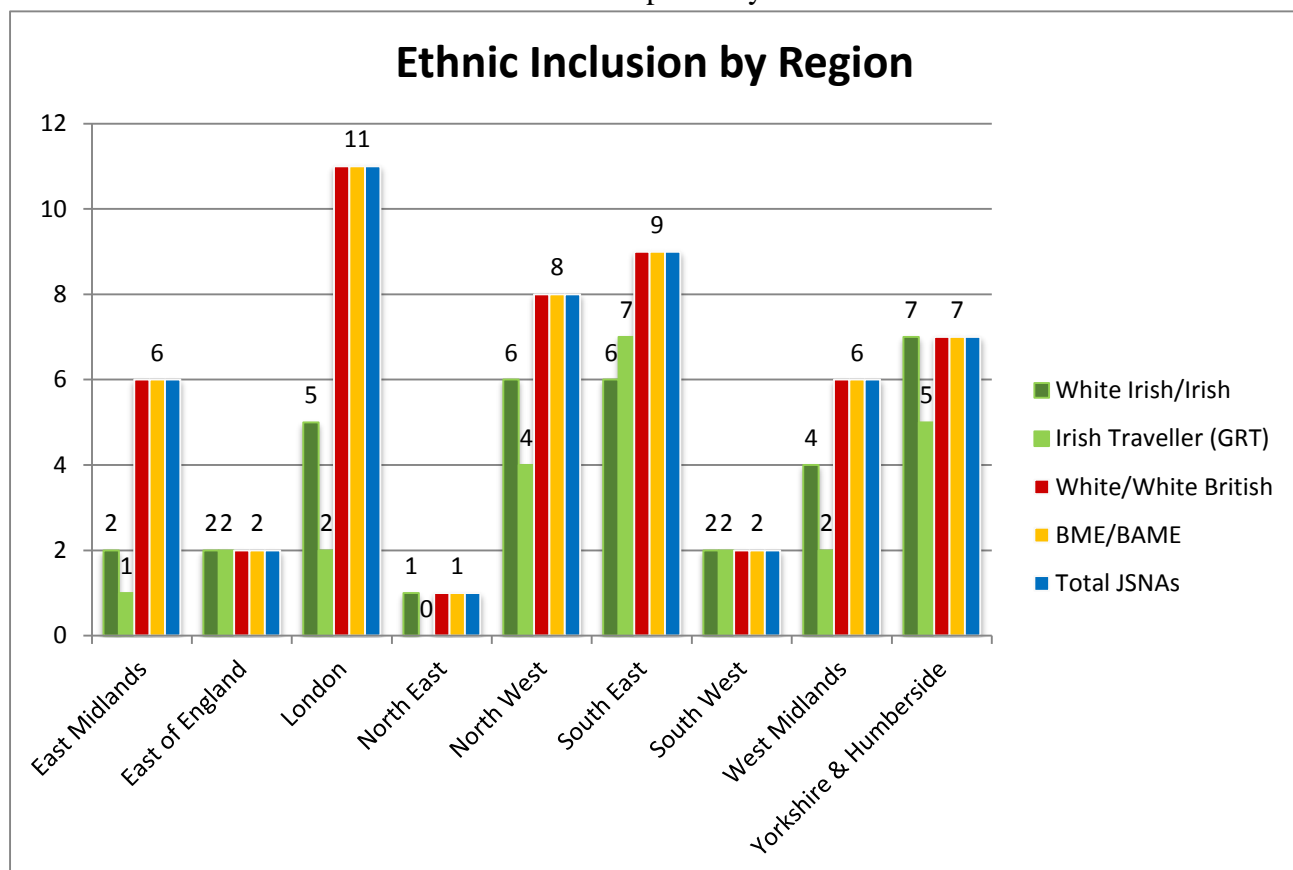
Table 5 (shown below) expands on the data shown in Table 4 and Graph 4 by specifying the JSNA reference count throughout the 9 regions we have examined.

	White Irish/Irish	Irish Traveller (GRT)	White/White British	BME/BAME
East Midlands	2	1	6	6
East of England	2	2	2	2
London	5	2	11	11
North East	1	0	1	1
North West	6	4	8	8
South East	6	7	9	9
South West	2	2	2	2
West Midlands	4	2	6	6
Yorkshire & Humberside	7	5	7	7

Table 5

Out of the 9 regions examined, Yorkshire & Humberside, North West, and South East have the highest amount of JSNAs which contained mentions of the Irish based on the raw data, where North East, East Midlands, East of England and South West all have the lowest.

If you view these numbers in proportion with the total number of JSNAs in the area, 100% of Yorkshire & Humberside's, East of England's, South West's, and North East's JSNAs have mentioned the Irish. East Midlands and London have the smallest proportions of references to the Irish with two out of six and five out of 11 respectively.



Graph 5

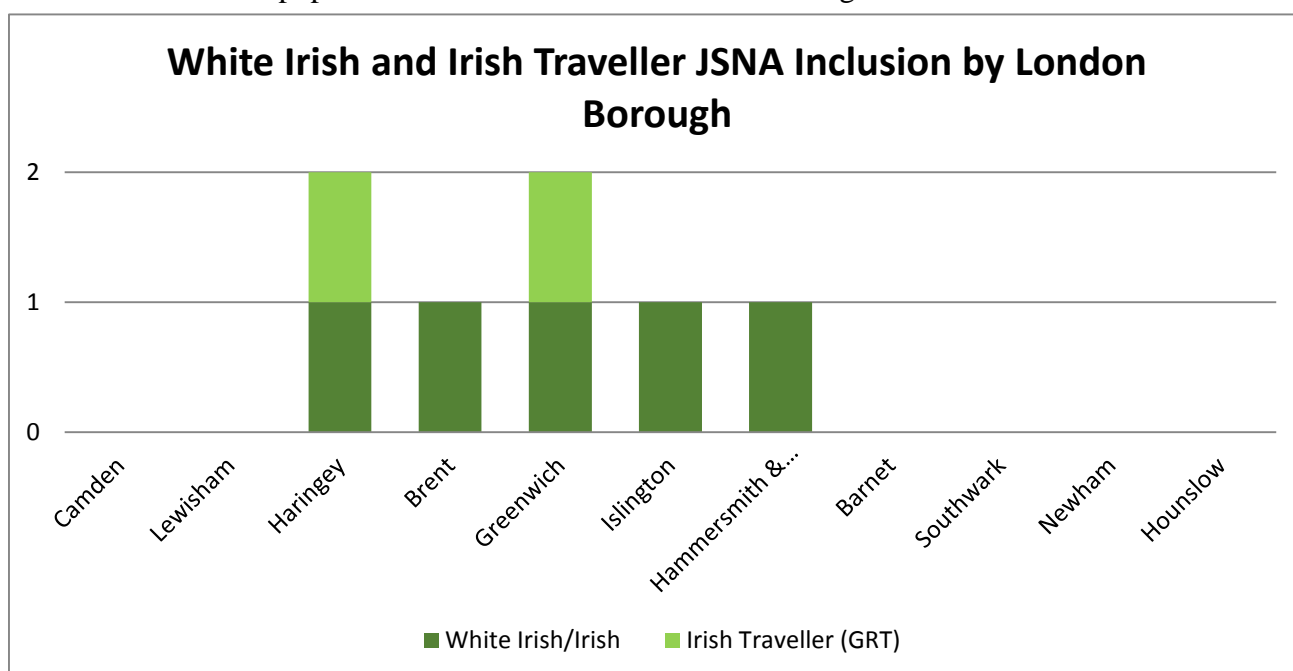
Taking into consideration the data from the original *Degrees of Ethnic inclusion* (2012) and the most recent survey, the number of JSNAs in London which mention White Irish has decreased by 4 (37%), with differences at local authority level.

	White Irish/Irish	Irish Traveller (GRT)	White/White British	BME/BAME
Camden	0	0	1	1
Lewisham	0	0	1	1
Haringey	1	1	1	1
Brent	1	0	1	1
Greenwich	1	1	1	1
Islington	1	0	1	1
Hammersmith & Fulham	1	0	1	1
Barnet	0	0	1	1
Southwark	0	0	1	1
Newham	0	0	1	1
Hounslow	0	0	1	1

Table 6

Table 6 shows us less than half of the London boroughs examined had mentioned White Irish anywhere in their JSNAs and only 2 mention Irish Travellers. Considering that the Irish comprise 2.2% of London’s population³ and a much larger proportion of some individual boroughs, it is concerning that the exclusion of the Irish from JSNAs has increased over the past 2 years.

There was no change in the number of times the Irish Traveller community who make up 0.1% of the London population was mentioned in London borough JSNAs.



Graph 6

³ <http://www.nomisweb.co.uk/census/2011/KS201EW/view/2013265927?cols=measures>

Phase 2: Health Demographics

Health Findings by Region

From The JSNAs were analysed for evidence of attention to specific health conditions or health behaviours of concern for Irish or Irish Traveller communities. The data is broken down by region:

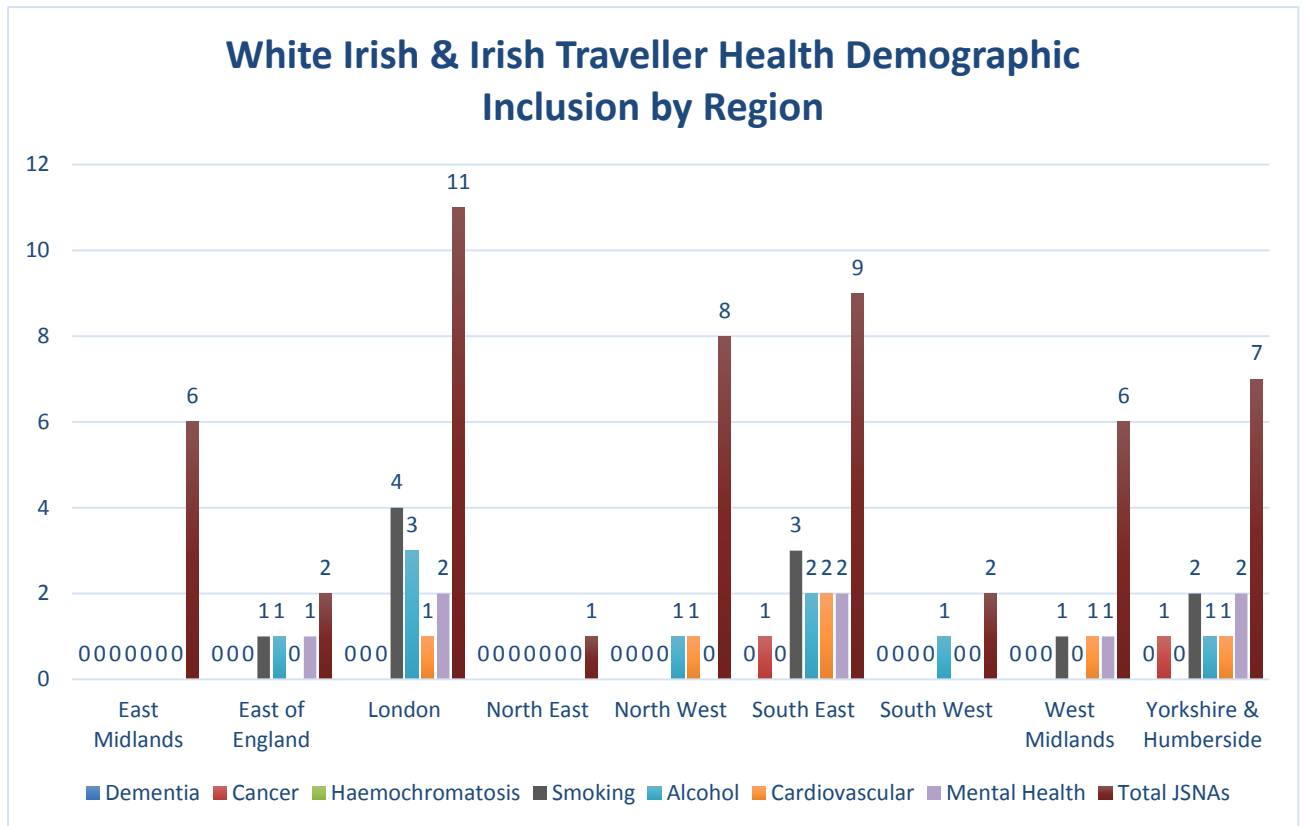
	Dementia	Cancer	Cardiovascular	Mental Health	Haemochromatosis	Smoking	Alcohol
East Midlands	0	0	0	0	0	0	0
East of England	0	0	0	1	0	1	1
London	0	0	1	2	0	4	3
North East	0	0	0	0	0	0	0
North West	0	0	1	0	0	0	1
South East	0	1	2	2	0	3	2
South West	0	0	0	0	0	0	1
West Midlands	0	0	1	1	0	1	0
Yorkshire & Humberside	0	1	1	2	0	2	1

Table 7

The North East had no mentions of the selected concerns. However, the East Midlands region also failed to mention any of the health concerns in any of the 6 JSNAs in that region. The South East region was most likely to mention cancer, cardiovascular disease, mental health, smoking and alcohol) along with London who identified cardiovascular disease, mental health, smoking and alcohol. Yorkshire & Humberside identified cancer, cardiovascular disease, mental health smoking and alcohol.

Since the original report East Midlands and Yorkshire & Humberside have stopped identifying specific health issues for the Irish community, while the South East had improved markedly in this respect, particularly in relation to. Irish Traveller communities who have a large presence in that region.

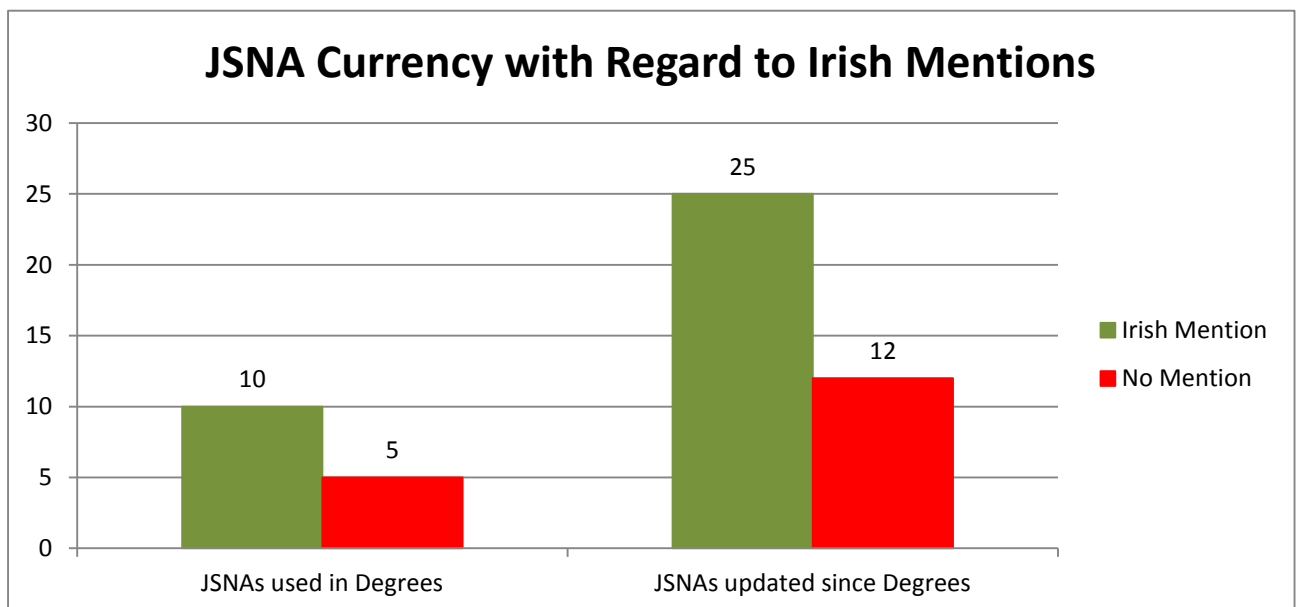
Some particular health issues for the Irish were more likely than others to be identified across the JSNAs. Smoking and alcohol were more frequently identified followed by mental health and cardiovascular disease. Unsurprisingly Haemochromatosis which is not a well-known condition but one which is common among Irish people was not mentioned at all. However despite the highest levels of cancer in the UK only one JSNA identified this as an issue to address. Although the Irish have an older age profile than the general population or other BME groups no JSNA identified dementia as a problem. The high levels of cardiovascular disease and mental ill-health in the older increase the risk of dementia for Irish people so it is worrying that JSNAs fail to recognise this growing problem for health and social care providers.



Graph 7

Updating JSNAs

It is important to note that not all JSNAs had been updated since our original survey. Some authorities reported that they had recently updated but had not yet published the renewed JSNA. Of those updated JSNAs which we analysed, some had included the Irish in the demographic section, whilst others had not. The JSNAs that were updated were slightly more likely to include the Irish.



Graph 8

Conclusions

There are clearly issues related to JSNAs in general. Recent changes in responsibility for public health, new commissioning structures and reduced resources, make for inevitable problems. Many JSNAs have not been updated so omissions in earlier documents have not been rectified. Others have switched to a continuously updated online document which does not have a demographic section, but instead links visitors to the most recent census data for the regions. While problems may be understandable, the statutory duty underpinning JSNAs must still be met.

JSNAs generally recognise the existence of local Irish populations but are largely failing in their duty to acknowledge the health disadvantage experienced by this community or to take account of their needs. This has deteriorated since the last survey. The low response rate to our survey is concerning as is the poor level of consultation with Irish third sector organisations. Despite being provided with relevant information and details of local Irish organisations, JSNAs are failing in their duty to consult with Irish agencies working with local populations. It is encouraging that more attention is being paid to GRT communities, particularly Irish Travellers although this is not necessarily translated into specific health action. Given the older age profile of the Irish population, the highest mortality rates from cancers, among the highest rates of cardiovascular disease and persistently elevated levels of mental ill-health and increasing evidence of dementia, JSNAs, Healthwatch and Health and Well Being Boards are failing in their equality and diversity duties.

While current arguments about the relevance of race and ethnicity continue, it is clear that for the Irish (and other BME groups) intersectional inequalities persist. Under representation and arguably exclusion leave a significant information deficit for statutory bodies responsible for improving health and addressing health inequalities. If JSNAs are to assess the needs of local populations and gauge what services to provide and groups to target, they are missing out a sizeable tranche of society. This is not only discriminatory, but can prevent the relevant authorities from strategically planning to improve health and wellbeing and narrow the equality gap as their statutory remit requires.

Recommendations

- 1) JSNAs must include the Irish in their demographic data analysis in order to track the growth or decline and the level of need of Irish populations.
- 2) JSNA bodies must consult and collaborate with local Irish third sector organizations to understand and the specific needs of the Irish community.
- 3) JSNAs must take account of the social determinants of health and specific needs of the Irish community as part of their BME strategy
- 4) JSNA publishing bodies should continue to improve their tracking and work with Irish Traveller communities to address their unique health needs.
- 5) That all Local authorities and services, as good practice, use the Census 2001 categorisation in relation to ethnicity

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