30 November, 2020

Healthwatch Birmingham response to Commission on Race and Ethnic Disparities in the UK

Healthwatch Birmingham welcomes the opportunity to respond to the Commission on Race and Ethnic Disparities call for evidence. As one of a national network of Local Healthwatch, Healthwatch Birmingham is mandated by Government through the Health and Social Care Act 2012 to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided in their community.

In line with our role, we have focused our comments on aspects of the 'call for evidence' that relate to health inequalities. Based on the experiences of health and social care we have heard over the years, we recognise that avoidable inequalities in health, cut across a range of indicators including the protected characteristics as set out in the Equality Act 2010. Therefore, a person's chance of enjoying good health and a longer life is determined by the social and economic conditions in which they are born, grow, work, live and age. These conditions also affect the way in which people look after their own health and use services throughout their life. In a place like Birmingham where the level of disadvantage/deprivation is higher than the national average, greater care needs to be taken to ensure that health inequalities do not increase, especially for those with protected characteristics.

Birmingham has one of the highest populations with more than 1 million residents. There are over a hundred different languages spoken in Birmingham. Some areas of the city are mainly (at least 80%) populated by residents from Black, Asian and Minority Ethnic groups. More than half of Birmingham's population is under the age of thirty. Forty-six percent of Birmingham's population live in the 10% of most deprived areas in England, which accounts for some very poor health outcomes. The city has a level of homelessness that is more than three times the national average, long-term unemployment two and a half times higher, and one in three children live in poverty. One in four people live with a mental health condition that started in childhood. There is a prosperity gap of 10 years between the most affluent and least affluent people living in Birmingham.

Our answers to this call for evidence are based on Healthwatch Birmingham's recent report *'Health Inequalities: Somali people's experiences of health and social care services in Birmingham'* including feedback we have heard over the year from ethnic minority groups. The report is based on interviews with members of Birmingham's Somali community, with a specific focus on:

- the challenges and barriers that negatively impact on Somali people's experiences of health and social care (both prior to and during the lockdown)
- the impact that service changes, due to the pandemic, are having on the Somali community
- understanding what could improve Somali people's experiences of health and social care services in Birmingham.

We found that the following issues have led to distrust and detachment from health and social care among the Somali community:

- lack of dignity and respect
- poor diagnosis and referral to specialist treatment
- cultural and language difficulties
- stigma and discrimination

We identified a number of important areas for improvement, including:

- communication, information and engagement
- education and training for both Somalis (English, rights) and health and social care professionals (cultural, stereotypes and discrimination)
- access to adequate and knowledgeable interpreters/translators
- diversity in recruitment to health and social care roles in local services

Below is our response to some of the questions raised in the call for evidence:

1. **What do you consider to be the main causes of racial and ethnic disparities in the UK, and why?**

The experiences that we have heard show that racial and ethnic disparities in health and social care exist because not all patients receive high quality health care. These experiences have resulted in a loss of confidence and trust in health care services. Consequently, a lack of trust has led to caution from individuals seeking treatment and a reliance on alternative sources of care and service. Most of the experiences shared with us show that often patients from ethnic minority groups feel:

(a) Dismissed by health care professionals, especially when English is not their first language. Below are some experiences we have heard:

> *I have realised also that when I am at the GP and I am explaining my symptoms, before I even say a complete sentence or finish saying what I want to say or explain myself, already the GP is prescribing something and he just says go and take that. I have dealt with that a lot.*
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> *[The dismissive attitude] it's not just me who faces it, a lot of people in my house, for example my parents for whom English is not their first language, we have to go and help them when they go to the doctors. I realise that they dismiss and disregard them a lot. My parents are older and my mom is diabetic and she has had a lot of problems with the GP where she has told them continuously to send her medication*

because she takes metformin which she can't do without. But this is often forgotten and she has actually had to fight with them over the phone and they will say 'We will do it' but won't unless she actually turns up at the GP or brings one of us with her cause her English isn't that great. We think it's because they think we do not know our rights.

(b) That there are very long delays in getting a diagnosis and a lack of referral to specialist treatment. Others felt that they are not offered the full range of evidence-based treatments. As this experience demonstrates:

I remember my sister had a problem when she did not speak the language and for years and years she struggled. My sister was suffering from a tumour for years and all the doctor would say is 'Take this depression tablet'. 10 years they gave her depression tablets. No real checks or investigations were done. 10 years down the line they found out she had a brain tumour. So, things like that some health services when they see the patient does not speak the language, they just try to close the cases quick. They don't give them the right help because that person does not speak English and would not know any better. They believe that you don't know your rights and don't offer you any extra help. Now my sister is 15 getting help but it's too late now because things like that you need to catch them early so it is affecting her now. 10 years she has been visiting her GP and for that long she had no support and there is no other explanation. Other than the fact that when you don't speak the language, that's it you don't get the help you need. Instead of offering extra help like an interpreter they are just pushed to the back saying they won't waste time or energy on that person.

(c) Cultural and language difficulties which often dictate the level of knowledge about systems, especially the health care system and people's rights within that system. Thus, affecting how the individual engages with that system and ultimately health outcomes.

I feel like they will only take you seriously if they know that you know your rights … I have noticed that when I go to the GP or hospital, if they know that I do know my rights then they tell me 'OK we will do this and do that' and so on. If you don't know anything then they try to feed you what they want. That's the challenge for my parents cause English is not their first language, they do not know their rights, what they can have or not have so they can easily be told that we don't do this or we don't do that unless someone else tells them.

(d) Experiences of racism and discrimination, more so where multiple inequalities(such as religion and ethnicity) apply to an individual, impact access to health and social care services, quality of care and health outcomes.

(e) Lack of a diverse health and social care workforce that reflects the community the service serves. This would improve communication, understanding, trust and experiences of care.

(f) Wider factors that contribute to racial and ethnic disparities is the environment in which people live. The people we spoke to during our Health Inequalities study (link above) live in the most deprived areas of Birmingham. People spoke about the lack of access to ESOL classes that used to enable people to learn the English language, closure of leisure centres and libraries in their local communities. People also spoke about other impacts such as housing, loss of income due to a loss of jobs during covid-19.

2. What could be done to improve representation, retention and progression opportunities for people of different ethnic backgrounds in public sector workforces (for example, in education, healthcare or policing)?

Based on the findings of our study, commissioners, Providers (i.e. GPs, trusts), Public Health England and Local Councils have an important responsibility for ensuring diversity in the health and social care workforce. There needs to be a better use of data (e.g. JSNA) in order to understand local communities and the needs within those communities.

People have told us of the importance of training people from ethnic minority groups in health and social care so they take up key positions within their communities. Thus the importance of having programs that target minority groups into training roles, this includes encouraging selection of certain subjects crucial to the field of health and social care various educational levels (e.g. A levels). Below are some of the experiences we heard during our study (link above):

> *There are no Somali people in public sector positions, no Somalis represented on boards, education sector of BCC or health sector, community groups. We have difficulties that other communities have but they have representatives working in various healthcare services that we do not have. There is no one representing us, who understands our culture, our system of living - no one defending our rights.*
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> *The only exit we have or solution is to have Somali community representatives in health and social care, otherwise things will continue to worsen.*
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> *To overcome some of the barriers Somali people face, we need to have - especially in the areas where Somali people live or are concentrated such as Nechells, Small Health and Bordesley Green - equal opportunity in employment. For example, to have GPs that represent the diversity of the community. Have a Somali speaking GP, nurse and receptionists in areas where you have a high concentration of these groupings.*

7. How could inequalities in the health outcomes of people in different ethnic groups be addressed by government, public bodies, the private sector, and communities?

Our report (link above) found that the following would improve the experiences of health and social care of minority ethnic groups.

- Engagement with ethnic minority groups or communities should not be a one-off event and should be an ongoing two-way process. Opportunities should be made available for the community to be involved in decision-making processes in health and social care.

- The delivery of tailored and accessible preventative health information/messages is needed to improve knowledge of conditions (i.e. diabetes, asthma, and high blood pressure), risk factors, access to health services and improved lifestyle choices.

- The digitalisation of health and social care services has the real potential to exclude people from minority groups, leading to poor health outcomes and exacerbate health inequalities.

- Translation and interpretation support needs to be adequate with knowledgeable interpreters/translators who are able to explain complex medical information.

- Experiences of racism and discrimination, more so where multiple inequalities(such as religion and ethnicity) apply to an individual, impact access to health and social care services, quality of care and health outcomes.

- Culture and language barriers have considerable impact on how care is delivered and accessed. This can lead to an inability to access information about health and health services, difficulties communicating with professionals and decision-making. Therefore, health literacy among ethnic minority groups is crucial.

- Trust is key in the relationship between health care services and ethnic minority groups. A lack of trust has led to caution from individuals seeking treatment and a reliance on alternative sources of care and service.

- A diverse health and social care workforce within services in communities with large ethnic minority groups would improve communication, understanding, trust and experiences of care.

- Improving understanding of health and social care and its services in ethnic minority communities and helping them to share their experiences with people who can effect change is crucial.

- Oral information is really important to some ethnic minority groups (e.g. Somali people) and written communication messages are inadequate in reaching these communities.

- Equitable access to health and social care services requires services and professionals to have linguistic and cultural competence. Including the ability to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This can include on the job training as well as including this in the curriculum.

- The interaction of various inequalities of religion and ethnicity demonstrate the need for health and social care to understand people's experiences on a case by case basis and a move away from grouping people under the broad term of BAME.

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- Commissioners, Providers (i.e. GPs, trusts), Public Health England and local Councils have an important responsibility for increasing understanding of services including preventative services; ensuring diversity in the workforce; ensuring access to community services (e.g. community centres, parks); and ensuring that there is meaningful understanding and identification of BAME communities through data to awareness of health and social care services available to various communities.

The issues affecting ethnic minority groups in relation to health and social care are multiple and complex. Addressing health inequalities is not easy but we hope that the findings in this report will lead to actions that improve the experiences of health and social care of ethnic minority groups.

Yours Sincerely,

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