

Race Equality Commission Submission

Introduction

Healthwatch Sheffield is here to make sure that people are put at the heart of care by those designing, funding, and running health and social care services in Sheffield. We're completely independent and not part of the NHS or Sheffield City Council.

Our purpose is to listen to local people, and use people's views and experiences to drive change and improvements in health and social care services. We encourage those in charge of local care to involve people in planning and delivering services. We recognise that Health inequalities in Sheffield are stark, and there is much which needs to be done to address this – this is the lens through which we do our work.

We do however recognise that Healthwatch Sheffield, its leadership, staff and volunteers is not diverse enough; we acknowledge also that we need to do more to make sure that we are hearing and amplifying the voices of people from BAME communities. This submission is based on what we have heard from different people in BAME communities, but we know not all experiences and voices will be reflected in it; we do not pretend that they are.

As a city we collectively need to create space and opportunities for people to speak, but also we need to foster a culture where people are ***listened to***, and action follows.

Evidence of racial inequality in Sheffield

This is a selection of experiences we've heard from individuals and from voluntary/community organisations over the last 18 months.

Our main sources of evidence are:

- A survey on people's experiences of covid-19
- Feedback and queries coming to us through our advice and information line
- Our #SpeakUp small grants programme (funding smaller voluntary groups to gather feedback through their communities)
- Interviews with people from BAME backgrounds in relation to the PHE report about disproportionate impact of covid-19
- Experiences shared through focus groups and other face to face engagement work
- Engagement work carried out by the CCG in relation to the interpreting contract

Here we are sharing a mixture of issues raised directly by people from BAME backgrounds, as well as wider issues that are likely to disproportionately affect these groups (eg language barriers and issues facing people who are newly settled in the UK).

We have tried to categories issues into themes for ease of reading. We know that the impacts of inequality do not fit neatly into these categories, so some of these experiences straddle several themes.

Where issues relate directly to health and social care services, we have suggested some actions which could go some way towards addressing them. We have included the recommendations in the relevant sections, but have included some overarching recommendations in a further section at the end.

Interpreting/language barriers in accessing healthcare:

Language

- Language and communication barriers make it difficult to make appointments and explain a health condition over the phone to a receptionist. People with limited English also find online booking difficult. ***"It is difficult as English is not my first language to communicate the medical terminologies over the phone"***
- Appointments need to be longer where interpreters are used – this doesn't always happen.
- Many people have to get assistance from family or friends to interpret for them. This means that young family members used as interpreters would miss school or college. ***"I have to translate for the older generations and they are uncomfortable asking other people (non family) to go to appointments with them."***
- People with English as a second language can find it difficult to find the departments or clinics because the hospitals are too big and they could not easily move around and understand the signage. Printed information is often too wordy, as are letters sent to individuals.
- Where GP receptionists can speak the first language of patients, this is much appreciated

Poor access to interpreters, or sub-standard interpreting, is described by some individuals as a significant barrier to accessing care and support. We have heard about a range of difficulties with the interpreting service which include:

- **Access** –people experiencing delays with health services because interpreters are not available. People are not given clear information in appointment letters to let them know whether an interpreter has been booked.
- **Telephone interpreters** –Lack of visual cues make it hard to communicate, and poor quality phone lines are sometimes an issue
- **Quality**– interpreters making mistakes, including using the wrong words for medical terminology.
- **Getting the right language** – provision of an interpreter who speaks the wrong language or dialect. This may be due to assumptions made about language, based on the person's country of origin.
- **Confidentiality** – some people, particularly women, described a concern around interpreters and confidentiality. In some situations, people may withhold important information because of this fear.
- **Awareness** – people felt that professionals needed better understanding of what it was like to use interpreting services, as well as better cultural awareness.

Healthwatch Sheffield has found it hard to drive change and improvement in this area despite raising it in many places and ways – quality monitoring of the contract does not seek out / use examples of people's lived experience.

Recommendations

- Commissioners ensure involvement of people using services at every stage of the commissioning cycle – for example by including them on steering groups when the specification is being written, but also in the quality monitoring of the service.
- Develop more robust systems for recording communication needs, with digital prompts for health professionals to ensure interpreters are booked where necessary
- Written information needs to be communicated as clearly as possible, without unnecessary jargon (for instance in appointment letters) to make this more accessible for people who speak English as a second or other language. The use of a readers panel to check the accessibility of this information could assist with this, as would staff training on the use of plain English and the Accessible Information Standards.

Understanding health systems:

Specific concerns relating to refugees and asylum seekers

- NHS charges deterring people from seeking essential health care
- The complexity of the HC1 application and the need to keep HC2s up to date – this is made more difficult by support services having to move online.
- Limited access to technology for health advice and support. The cost of phones/laptops is a barrier, as is the lack of WiFi in asylum housing. This issue was made more acute by Covid. In our Covid survey one person told us:
“Can’t access anything online cause I’m an Asylum seeker. I couldn’t access regular stores, government didn’t provide many assistance”
- Many asylum seekers and refugees are not aware of the range of health services that are available. Many people do not know how the NHS works, or how to make the most of accessing the services.
- There is a clear need for health and wellbeing information among refugees and asylum seekers.
- People new to the UK have a desire for more workshops on understanding the NHS and how to access its services, as well as preventative health and wellbeing awareness and resources.

Other experiences related to understanding health systems

- Many people with English as a second language did not realise that they could complain if they were not satisfied with their GP or hospital care, or did not know how to make a complaint.
- Confusion about NHS charging for people who have come from abroad.
- Specific issues around BAME men, who said they did not know about mental health services and said that they would not visit a GP to discuss their mental health unless they had symptoms that were uncontrollable or posing a risk.
- Members of Sheffield’s Chinese community who had used social care services stated that it was hard to find out information about services. Instead, they turn to other service providers such as The Sheffield Chinese Community Centre and Citizens Advice Sheffield.

- Some people from BAME backgrounds said they didn't know where their GP practice was and how they would make an appointment.

Recommendations

- **Provision of workshops/easy to understand information to help people understand how the NHS and social care systems work. This would be especially beneficial to people who are new to the UK.**
- **Statutory services to work with trusted voluntary organisations to reach out to wider communities and share information with them; this relationship with the VCS should be a strategic partnership not a transactional commissioning relationship.**

Issues related to education and employment:

- People told us that the disproportionate impact of covid on BAME people reveals a “wage-gap related to race within Sheffield” – they called for improved access to higher education to improve employment prospects/social mobility.
- Young people from the Asian community told us they were worried about those on zero-hours contracts who have may have lost their earnings due to covid.
- New arrivals to the UK told us about issues ‘comparing certificates’ (how their own qualifications were compared to English qualifications). E.g. ***“I was a doctor in Libya; I'd like to return to medicine”***. People have a real desire to ***“have value in my community to support others and have a healthier family”*** by using their skills, but having to ‘resit’ exams or compare qualifications for professions people are well experienced in can be demotivating and affects confidence.
- Not being able to work and support their families was causing sleeplessness and depression for asylum seekers.
- Unemployment was a major stress factor; skilled professional adults weren't able to find work.
- Exclusions from school - BAME students worry about being stereotyped.
- Opportunities to practice English skills in various ways is lacking. People from BAME backgrounds in various engagement activities have told us they want more useful learning opportunities, and more information and advice relating to learning English, health literacy, financial literacy, and social support/activities.

Experiences of discrimination/other inequalities:

Fears related to covid

- Regarding rules mandating face coverings in shops, we heard from one young black man who told us he felt unsafe covering his face in shops, due to the suspicion he already faces from staff
- People told us they were worried about increased discrimination and attacks on people of East Asian origin, which lead to fears of going for walks, to the shops etc
- Fear of the disproportionate impact of Covid on people from the BAME community.

Discrimination and structural racism in healthcare settings

People we interviewed in relation to the PHE covid report have shared strong feelings with us about wider structural racism in health services and their experiences in accessing treatment. They described:

- *“Most of us have some anxiety in accessing health care or using other forms of public and private services [...] There is always an aspect of us not being believed - a political or racialized reaction to our identities or worse. These attitudes can get taken into our treatment support and many more things”*
- *“Even if all other health inequalities were removed, health services are systems fuelled by racism in which patients and staff of colour are known to be offered less support either medically or as an employee.”*
- *“We are dying at the hands of the very systems that are supposed to keep us well and safe”*

Cultural Sensitivity in healthcare settings

- Organisations working with refugees, asylum seekers, and others from the BAMER community felt that there was a need for further training on cultural sensitivity for health care professionals.
- Language and culture can perpetuate stigma and stereotypes, leaving young people targeted and bullied for struggling with mental health problems.
- Cultural and social factors affect the level of trust, and more awareness of cultural background was needed. Roma students expressed they did not trust their doctor because they did not listen to them, appointments were rushed, and they did not have enough time to make them understand the issues.
- Asylum Seekers and Refugees described challenges adjusting to life in the UK and they expressed that the health professionals did not want to know what circumstances led them to seek asylum or become a Refugee.
- In hospitals, the lack of provision of Halal food was also a concern. Many people told us they took food from home for their sick relatives because the selection was poor and it was expensive. This has also arisen through our Covid-19 survey, with respondents telling us about a limited amount of foodbanks offering halal options.

Wider experiences of discrimination

People from various focus groups/engagement activities we run have told us about:

- Judgement based on the colour of your skin and culture. People are particularly worried about the impact of this on young people’s mental health.
- A visual lack of role models in the community/city
- Feelings of powerlessness when faced by injustice

Physical environment and transport

We have heard from a lot of people about issues with public transport in parts of the city with a greater level of deprivation, as well as lack of access to safe outdoor spaces and activities for young children and families. This will impact disproportionately on people in Sheffield from BAME backgrounds.

Wider analysis and recommendations

Health and social care bodies do engagement to meet statutory requirements. Often they don't go beyond that, resulting in patchy understanding of some issues and how they impact on certain communities.

- **Engagement strategies in statutory bodies need to address this issue, and be clear and transparent about what approach they are taking.**
- **Closer working between engagement teams, commissioners and providers so that engagement is not a 'bolt on' which happens at just one point in the commissioning cycle, but weaved through the fabric of all service delivery and quality monitoring.**
- **Engagement needs to be allocated adequate resource, with specialist leads, not merged with other roles where it may be 'lost' or overshadowed by other demands. Equally, teams leading on equality need to be separately and adequately resourced.**

People tell their story and experience many times, without feeling heard and without seeing change.

- **The system needs to respond in a timely way when issues are raised, identifying leads to take ownership of driving improvement in a particular area. Systems to track actions from reports.**

Boards and decision making bodies are not diverse; decision makers and leaders are largely white.

- **Find new and creative ways to involve a wider range of people and organisations in places such as the Health and Wellbeing Board – e.g. by holding public meetings in different venues.**
- **Introduce mentoring and buddy schemes for people interested in becoming leaders.**
- **Existing strategies, such as the Health and Wellbeing Strategy, could be used more effectively to drive change but need more teeth and action sitting under them.**

Health inequalities – there is much discussion around health inequalities, and little progress. This has been compounded by Covid, but was a pre-existing issue.

- **Be guided locally by recommendations in the Marmot report; many of these require national action, but some could be progressed at a local level. Develop a cross system / cross party Health Equality Commission to develop a health inequalities action plan– this group to include representation from communities affected by health inequalities (groups and individuals may need paying for their time to participate).**