Doncaster Council

Report

Black and Minority Ethnic Health Needs Assessment; Community Engagement

February 2018

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Introduction

Background to this Health Needs Assessment

During 2016 a multi-staged Health Needs Assessment for Black and minority Ethnic (BME) communities was commissioned by the Doncaster Health and Wellbeing board (HWB). This work was undertaken by the Doncaster Public Health team under the oversight of the Health Inequalities Working Group to address health inequalities across the Borough.

This HNA was presented to the HWB in March 2017. The HNA consisted of;

- **Phase 1:** An analysis of baseline demographic data on BME groups from previously collected data such as national census data.
- **Phase 2:** A review of evidence from published literature surrounding ethnicity and health. Evidence reviewed included that on access, mental health, housing and harassment.
- **Phase 3:** Stakeholder engagement. The approach consisted of feedback via Doncaster Healthwatch, re-analysis of previously collected focus group data and survey data from HWB member organisations.

The data driven approach of the March 2017 HNA meant engagement with BME populations across Doncaster was limited. This work builds on the initial HNA hoping to bring further detail and clarity to the findings.

Aims of Community Engagement

Underpinning the community engagement arm of this HNA are the overall aims set in commissioning the original HNA. In summary, this is to identify and examine any *invisible* factors that lead to health inequalities in ethnic minority groups in Doncaster. The purpose of this HNA is to make these *invisible* factors *visible* and make actionable recommendations that will address these causes of health inequalities.

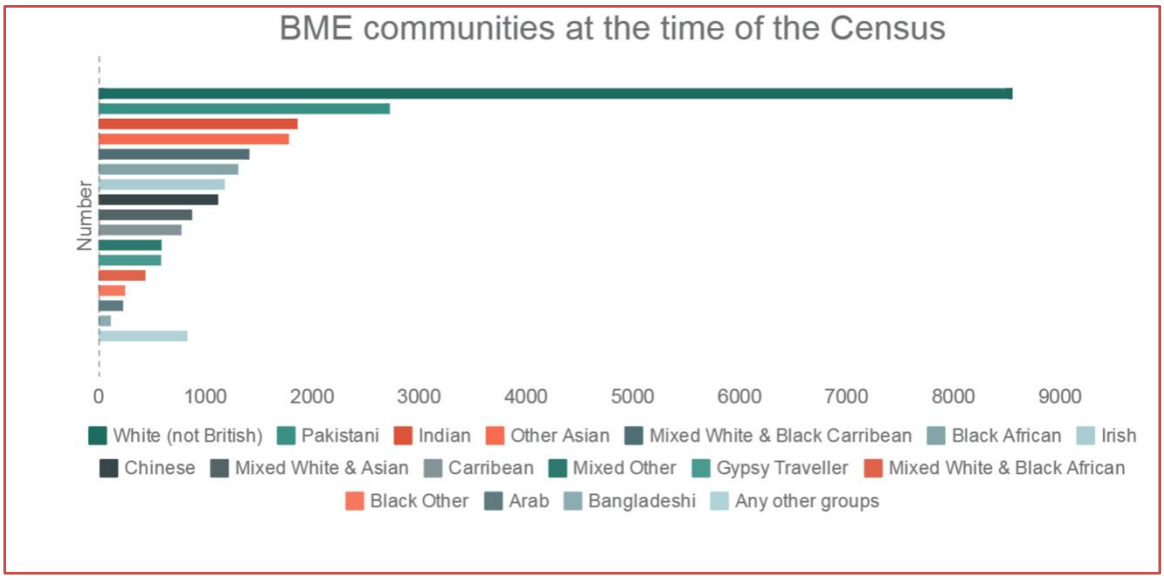
Objectives

- To explore the perceived health needs of key BME populations in Doncaster through direct community engagement
- To explore ideas of how these needs could be met or resolved
- Reconcile findings from this piece of work and the existing HNA to formulate actionable recommendations to address the identified health needs
- To establish a mechanism for engagement with BME groups in Doncaster on the health inequalities agenda

Methodology

Identification of key groups

The figure below was used in the original HNA report. It highlights the relative sizes of different BME community groups across Doncaster. A wide variety of ethnic groups are resident in Doncaster. To focus our time and resources effectively, we used this figure to identify and prioritise the largest ethnic groups to engage in discussions.



The March 2017 HNA identified that migrants and new arrivals were a key group for further attention. This priority reflects the migrant data collected subsequently to the 2011 National Census. For example, an analysis of spoken languages in Doncaster detailed in the March 2017 HNA report shows that Polish is the largest minority language spoken. This is likely to represent the large proportion of the 'White not-British' population documented in the above figure. Additionally it is documented in 'Migration Yorkshire 2016' that in 2015, for example, there were 3490 new migrant workers to Doncaster. This significant migrant working population are clearly important to engage, despite not perhaps being fully represented in the 2011 national census data.

Through the reasoning detailed above, we sought engagement with the following BME groups;

- Asian (including Pakistani, Indian and other Asian)
- Chinese

- Afro-Caribbean (including mixed white and black Caribbean and Caribbean)
- Polish
- ‘New Arrivals’ (focussing on asylum seekers and refugees, likely to represent a variety of Ethnic Origins including Black African and Middle Eastern groups)
- Gypsy Traveller

Recruitment

Opportunistic sampling was employed to gain access to ethnic minority communities through community gatekeepers. These gatekeepers were known community group leaders, religious group leaders, Healthwatch representatives and members of existing ethnic minorities working groups in the council. Gatekeepers then used their existing community networks to engage and recruit participants.

Methods of Engagement

Separate meetings were arranged for each key ethnic group and focus groups were undertaken. A brief presentation was given by Public health to each group providing background and the aims of the meeting. The focus groups were facilitated by Public Health Team members and two key questions were asked;

1) What issues are of main concern for your community?
2) What could be done to improve these issues in your community?

Groups were encouraged to think broadly about issues rather than constraining themselves to perceived health related topics only. Groups were then encouraged to prioritise the issues identified and focus their discussions more on their priority topics.

Data capture and analysis

During the focus groups, facilitators captured key topics that emerged through discussions. In addition, groups had post-it notes to document any key issues they felt they did not have the opportunity to discuss. These notes were then collated and analysed for key themes within the data and similarities in themes between groups.

Checking Recommendations

After completion of all the focus groups, participants and local partner organisations were invited to attend meetings where the report and recommendations were ‘sense checked’. The recommendations in this report are a reflection of these meetings.

Limitations

Due to the resource intensive nature of qualitative investigation and reasonable time constraints, only a small sample of each sub-population was engaged in focus group discussions (approx. 5-10 members of each community). However this did allow us to conduct focus groups with a broader range of sub-populations to ensure a voice is given to a wide variety of community groups. Furthermore this allows us to understand which issues are unique to particular minority groups or those that are associated more generally with being a member of a minority community. We considered saturation to be met once similar themes are re-occurring amongst sub-populations.

The 'gatekeepers' used to recruit focus group participants were mainly associated with an existing community group such as a church. It is likely therefore that those members of the public, who are disengaged from their broader community, may not have their views proportionately represented in our findings. However, the general tone of focus groups was that participants acted as 'spokes people' for health issues seen in their communities rather than personally experienced. As a result it is likely that the more vulnerable and excluded members of communities had their issues advocated for through the recruited participants.

Furthermore, a summary of the findings from each group was disseminated to the broader community through the focus group participants. This served to confirm the accuracy of points captured and ensure no key points were missed. This was performed in attempt to capture the voice of the broader community.

Results and Recommendations

When examining the themes emerging from the various focus group discussions, there were some topics that were important to all groups. These were themes around barriers to accessing health care, employment, mental health and social isolation. However there were some issues which were specific to one or two particular communities. In this results section, not every single issue that arose will be reported, but those that emerged as important or common.

Barriers in Accessing Health and Care Services

Part 1 of this HNA identified access the health care services in BME groups as a problem. It was recommended that more local insights were required for a fuller assessment of this issue in Doncaster.

All groups, except the Afro-Caribbean group, identified language as a barrier in health services. Participants accepted that interpreters reduced this barrier, but highlighted that there is a lack of interpreters from outside the patient's own communities. In turn this was felt to restrict a patients' ability to speak openly and with anonymity. The South Asian group particularly noted that anonymity was difficult within their community. It was noted by several groups that where telephone interpreters are used, communication is often difficult as there is no body language to aid understanding.

Recommendation 1: Where needed, review existing guidance on the use of interpreters in the public sector (for example health care). This guidance should state that;

a) A face-to-face interpretation is preferable to telephone interpretation services.
b) Patient preference should be sought on if an out-of-area interpreter is required. This aims to reduce the patient's perception of lack of anonymity within a consultation.
c) To reduce barriers in access to services organisations must ensure their front-line staff (i.e. receptionists) are fully aware of interpretation policies.
d) Organisations must undertake meaningful monitoring and evaluation of their interpretation services.

Recommendation aimed at: Doncaster interpretation and translation unit- Katy Scott, Primary Care, Doncaster Hospitals, Big Word Translation Services.

In some cases, it was not only language that impeded a health care consultation, but a lack of cultural understanding on behalf of the organisation or individual delivering

the health or social care. An example of this was discussed by the South Asian group that General Practitioners (GPs) may be misidentifying mental health problems as they commonly manifest as physical health problems. The Afro-Caribbean community felt that elderly members of their community experienced poorer quality social care due to a lack of knowledge in staff of their specific cultural needs. The Polish community felt that cultural barriers, and at times discrimination, meant GPs restricted their ability to access referrals to secondary care services.

In some communities specific cultural factors prevented engagement with services. These cultural issues included taboo and stigma surrounding alcohol use and the consequent denial of problem use, noted by both the Chinese and South Asian groups. For the new arrivals community, a basic lack of health knowledge surrounding mental health prevented people identifying and seeking help for these problems.

Recommendation 2: A commitment to training local GPs, hospital and social care staff on providing a culturally sensitive service to the BME community. Key issues this training should address are;

a) Reflection on staffs own beliefs, values and attitudes and how they impact on the clients they work with.
b) The different symptomology of some medical conditions in BME groups
c) Understanding religious connotations and cultural taboos relating to some conditions including alcoholism and mental health problems.
d) Providing practitioners with the skills and confidence to explore hidden issues of alcohol and substance misuse in the BME community.
e) Ensuring 'cultural needs' are asked about and addressed in care plans.

*Recommendation aimed at***:** Primary Care, Health and Social Care at DMBC, Doncaster Hospitals

The new arrivals community and the Polish community discussed practical issues hindering their access to health care. Both groups noted that communities had a lack of knowledge in navigating appropriate health services. New arrivals often may not know they need to register with a GP. The Polish group noted that securing a GP appointment was very challenging due to the lack of availability of appointments. On failing to secure a timely GP appointment participants said they would access Emergency Services instead. Furthermore, many new arrivals felt confused about the rules relating to financing healthcare and the fear of payments prevented or delayed their access.

Similarly the travelling community experienced difficulty registering with GP practices. Caravan sites are sometimes not viewed by practises as a "permanent address". It was reported that some patients have been removed from practice registers when surgeries realise that the patient is from the Traveller's community.

Furthermore dental registration among the Gypsy and Travellers community appeared to be a major gap, as one member acknowledged this “never happened”. The experience of “bad teeth” was acknowledged among the Gypsies and Travellers community.

Recommendation 3: Continue with the on-going work to increase access to primary care. Particularly to;

a) Increase timely access to GP appointments across all GP practises
b) To assist new arrivals navigate health care services
c) Improve access to registration with GP and dental practises for patients from the Gypsy and Travellers community
d) Monitor the impact that new ‘entitlement checks’ have on access to healthcare

*Recommendation aimed at***:** University of Sheffield Research Team on online tools for primary care, Health Access for Refugees Programme (HARP), Doncaster CCG, HealthWatch

The Gypsy and Traveller’s community group explained families like to stay together as family units in the community. They described that this is one of their core values. This principle extends to the care of the elderly. The community opts to look after their elderly people rather than let them be cared for in care homes. One of challenges associated with this is that the elderly among the community do not access services, unlike their counterparts in the wider community.

Recommendation 4:

a) To further explore of the needs of the Gypsy and Travellers community specifically relating to the needs of the elderly and the issue of domestic violence. Subsequently instigate culturally appropriate support services.
b) To gather information, build partnerships and facilitate engagement with this community, it is necessary to consider employing a link worker from within the community. Existing links with the community need to be made more widely known and a clear pathway of accessing these links needs to be established.

Recommendation aimed at: DMBC, Doncaster CCG

Mental Health and Social Isolation

The most discussed topic across all focus groups was Mental Health. Mental health problems were mainly discussed in the context of the perceived high rates of anxiety and depression in their communities. Multiple reasons were discussed for the high prevalence of mental health problems in the community. Despite its prevalence, it was also noted that often mental health issues were unrecognised by individuals and

were not discussed openly within community groups. Below is a list of reasons presented by each group detailing why they felt issues of anxiety and depression are so common;

- Chinese Group: Debt problems caused by gambling, lone living, high educational expectations, unemployment, carer stress
- South Asian Group: Changing familial expectations, loss of respect for the elder generation, social isolation, high levels of community judgement and disapproval, a tension between western and Islamic lived lives
- Afro-Caribbean Group: social isolation, lack of meeting places
- New Arrivals Group: separation from close family members, social isolation, high levels of poverty, immigration status, boredom, traumatic journeys to the UK, trauma from home country, food and housing insecurity
- Polish Group: Poor work life balance due to long working hours

Compared to all other groups mental health was most discussed by the new arrivals participants, and the severity of its impact appeared greatest within this group. One participant said “I struggle to learn new things”, where others said poor mental health resulted in panic attacks and thoughts about suicide. Almost all participants linked immigration status as a major stressor. Others assigned their anxiety to trauma saying,

> “The things I have seen…I have seen lots of death”.

The South Asian group and the new arrivals group noted that religious beliefs can complicate the issue of mental health. They described that often mental health can be interpreted as a religious problem such as spiritual possession or that the person has a “weak faith” (Link to Recommendation 2).

Recommendation 5: Commissioners and providers of mental health services should devise an action plan on how to tailor their services to also address the needs of the BME community. This will include ensuring;

a) Services are culturally sensitive
b) Language barriers are considered and addressed
c) Referral pathways are examined to enhance BME access to existing services
d) Consideration of BME needs in any future policies which are developed

Recommendation aimed at: RDASH, Doncaster CCG

Linked to mental health in all group dialogues was the issue of social isolation. This was noted to be a particular issue for the elderly and for women. Most groups identified language barriers as a cause, as well as the break down (or loss) of traditional family and community support structures. The barriers to leaving the

house identified included fear of harassment, and crime, bad weather and cultural expectations of women being carers for the home and family. For the new arrival community, social isolation resulted more from the lack of incentives to leave the home as they have no employment, very few friends and no money to pay for public transport or leisure activities. The Chinese group were concerned that social isolation means that many people are invisible to services and communities and that people may “fall through the gaps”.

Recommendation 6: Ensure that those working on the Loneliness and Social Isolation agenda across all directorates at DBMC are made aware of the burden of social isolation amongst the BME community in Doncaster. For those moving this agenda forward, to examine how the specific needs of the BME community can be addressed. This should include ensuring that existing services, such as local befriending schemes, are made culturally appropriate and accessible to the BME community.

Recommendation aimed at: Loneliness Lead within the Public Health Team (Louise Robson, Mental Health Steering Group (Emma Smith), Wellbeing Team (Lisa Swainston), DMBC

Social isolation was assigned to a lack of community meeting spaces in three groups. Community meeting spaces were viewed as positive places where people can meet to reduce isolation and improve community cohesion, as well as places to deliver programmes and educational messages. Lack of cohesion between ethnic groups was viewed as a particular issue by the Afro-Caribbean community. Participants noted there are often tensions between well-established settled communities, and communities of new immigrants.

Recommendation 7: Establish a working group to explore the community assets of buildings in Doncaster and how they could be used as community space. This group should focus on collaboration and partnership working. It should include members of the general public, including representation from a variety of BME communities. This group may consider examples of good practise from other regions. The group, led by a member of the council with expertise, would need to collectively determine;

a) The purpose for the community space (i.e. a multicultural space, a space for celebrations)
b) The location and building type (i.e. a location to maximise access from BME groups)
c) How the space could be managed (i.e. considering community ownership, volunteering)
d) How the space would be funded (i.e. crowd funding, sponsorship, social enterprise models)

e) Look for examples of best practise in other areas, and learn from previous endeavours locally.

Recommendation aimed at: Lead from DMBC Communities Team (Fay Wood-Community Led Support).

Substance Misuse

Alcoholism was seen as a very important issue by the Chinese community, especially amongst males. They assigned this problem to boredom and lack of awareness of safe drinking levels. They described it as a "hidden issue" where many men would not admit to their community or to services that they were problem drinkers. Similarly in the South Asian community they noted that drug and alcohol use were important but unrecognised and hidden issues. The cultural and religious taboos relating to alcohol force many to drink in secret, with this stigma preventing access to services.

Recommendations for substance misuse, namely alcoholism, link into those that address the causes such as unemployment and social isolation (recommendation 5, 6, 10). Furthermore they link in with recommendations on ensuring services are culturally appropriate (recommendation 2 & 4).

Recommendation 8: Highlight the hidden issue of alcoholism and substance misuse in some BME groups to the relevant teams tackling this issue within the council. Ensure that the local alcohol and drugs strategy is tailored to these communities finding innovative ways at engaging and addressing this problem.

Recommendation aimed at: DMBC Theme Lead on Vulnerable People (Helen Conroy and Andy Collins for Alcohol).

Gambling

A subject of great importance to the Chinese community was the issue of gambling. They were concerned that it was hidden, but very prevalent issue in their community which results in problematic debt and is a pathway into poverty. They described high stakes gambling of cars and businesses. They were also concerned that gambling companies often provide sponsorships of local Chinese community events.

Recommendation 9: Through the 'Gambling in Doncaster and Financial Inclusion' group, ensure that there is an action plan to address the issue of Gambling within the Chinese community. It is important that this specific issue of sponsorship of local Chinese community events by gambling companies is addressed.

Recommendation aimed at: Gambling in Doncaster and financial inclusion group – Caroline Temperton/Rupert Suckling

Nutrition

Nutrition was extensively discussed by the South Asian group, and only perhaps touched on by others. In younger people it was felt there was a large reliance on unhealthy take-away foods. Furthermore it was felt that traditional foods consumed at home were highly calorific and often used very few fresh fruits and vegetables in the cooking. They explained that there is a cultural expectation to cook these unhealthy foods when hosting. Interestingly the men in the community felt they had no control over improving what they ate at home as women had the responsibility for cooking, whereas the women felt disempowered by their families to cook healthy foods.

Recommendation 10: Establish a piece of work to explore ways in which BME communities (most notably the South Asian, African, Chinese, and Caribbean communities) can be supported to cook healthy foods and be encouraged in physical activity. This piece of work should be creative, empower and involve the communities they are targeted (such as micro-grants and resources for community groups to lead their own healthy cooking classes).

Recommendation aimed at: DMBC Public Health Team Physical Activity Lead (Claire Henry) and Obesity Lead (Louise Robson)

Education, Employment and Opportunities

Education, employment and opportunities was a strong theme present in all focus group discussions. Most groups noted unemployment as a concern. A common theme was discrimination causing inequalities in education and employment. This included being labelled as a 'problem' in education and being faced with the barrier of discrimination when applying for employment.

Recommendation 11:

a) Perceived discrimination when applying for jobs is problematic in the BME community. To address this, the equal opportunities requirements for Public Sector organisations should be extended to cover Private sector organisations and companies. Both public and private sectors organisations need to demonstrate due regard in relation to recruitment of BME groups.
b) Equal opportunities for BME groups in education, needs to be a goal. The findings of this HNA need to be considered by the education department in the council. A plan should be developed on how to decrease discrimination and enhance opportunities for BME children and young people in education.

Recommendation aimed at: Doncaster Growing Together

An emerging theme in several groups was the inequality in opportunities and its impact on the aspirations of young and working people. One group noted that young people were leaving Doncaster because of the limited opportunities available to them as a BME community member. One Afro-Caribbean participant summarised, “certain job roles just feel unachievable to a black person”. It was strongly noted on several occasions that there was a lack of political representation of the BME community, and more generally, a lack of role models in positions of power. It was said that this lack of representation damped people’s aspirations.

Recommendation 12: The creation of a BME advisory group to the council to increase BME political involvement and representation. This advisory group would meet quarterly. The group will provide a channel of accountability and feedback to the community on the progress of this HNA’s outcomes.

Terms of reference will be developed for this group using examples of good practise from elsewhere. A fair process of recruitment to this group will be developed by the strategy and performance unit.

Recommendation aimed at: Public Health Team, Health Inequalities Board

Again for the new arrivals community the barriers to employment discussed were somewhat different. It was highlighted by many participants that as an asylum seeker you have no right to work, but that poverty sometimes forced people into illegal employment, particularly if someone is a failed asylum seeker but is unable to return to their home country. Barriers to education in this group included lack of spaces on college courses to learn English and lack of childcare provisions in those who did have an opportunity to attend college. It was noted that childcare is a particularly difficult issue as many new arrivals have no social resources for informal childcare arrangements, and no financial resources to fund formal childcare.

Recommendation 13: Providers of ESOL courses should increase the number spaces available for new arrivals. Providers of these courses should consider how to improve access to these courses, especially for parents with problematic childcare responsibilities.

Recommendation aimed at: Local providers of ESOL (local colleges, charities), *Katie Scott- Refugee support in DMBC*

Crime

Crime was only discussed by the South Asian and new arrivals groups, however was an emphasised topic in both discussions. In the South Asian community there is growing concern regarding the incidence of Islamaphobic attacks, as well as robbery

and burglary and the impact on the frail, young and vulnerable. These issues feed into other themes, as it was discussed this backdrop of crime results in anxiety and social isolation.

Recommendation 14: For Team Doncaster to lead by example to demonstrate a zero tolerance policy to discrimination on the grounds of race. This zero tolerance policy is to be adopted by all members of the health and wellbeing board. The implementation of this policy should be reflected in the practise of each organisation such as providing robust reporting procedures for issues of discrimination.

Recommendation aimed at: Doncaster Growing Together, All partners of the health and wellbeing board.

The new arrivals group highlighted the important issue of exploitation. Stories were told of exploitation by drug dealers and gangsters as work is performed in exchange for housing in those that are desperate and destitute. Participants explained they are afraid of seeking police help for their issues of harassment, blackmail and threats, in case they get deported. Others were afraid of being implicated in criminal activities therefore felt trapped in a cycle of exploitation. Other members of this community said they felt unsafe because of the threat of terrorism in the UK. One participant noted,

"I feel like the war is following us… I fled from war and now the war has come here"

Recommendation 15: Raise awareness among all partnership organisations as to;

a) What the signs of modern slavery and exploitation are
b) What to do if anyone sees or suspects exploitation is taking place

Recommendation aimed at: Safer, Stronger Doncaster Partnership, Doncaster Growing Together, and South Yorkshire Police- Modern Slavery Team.

There was acknowledgement that domestic violence occurs amongst the Gypsy and Travellers community. However, it was explained that common practise is for the family to attempt to resolve the issue, rather than the police (Link to recommendation 4).

Housing

The new arrivals participants mentioned housing as an issue on multiple occasions. Participants said the housing they were provided with was often of very poor quality. Complaints included houses being very dirty, worn carpets, blocked sinks and toilets and excrement on the bathroom floor. Distress was caused by being expected to

share a bedroom with another unknown adult, often from a different country and background. It was described this caused tension in the different expectations around the home, for example, between those who drink alcohol and those that do not. Participants noted that often there was inadequate equipment in the home, for example a single shelf freezer between six residents, or no cooking equipment at all. People explained this meant they often couldn't buy, store and cook food so ate takeaway or instant foods.

Recommendation 16: The creation of minimum standards for housing in response to the poor housing conditions experienced by many asylum seekers and refugees. These standards will include items such as;

a) The provision of sufficient cooking and food storage appliances
b) Regulations against bedroom sharing for adults who are not members of the same family
c) A pathway for people gaining their refugee status to ensure that homelessness is avoided during the transition period

Recommendation aimed at: G4S, St Legers Homes, Complex lives

Accommodation was also an issue for the Gypsy and Travellers community. They noted that many object to Gypsies moving into their neighbourhood and, as a result, they faced racism. The fundamental desire of this community is to live together as a community. They explained they do not like being separated by being given individual family housing units that are scattered around Doncaster. Hence, they prefer traveller sites, not housing.

Recommendation17: Doncaster Council and St Leger Housing to work closely with the Gypsy and Traveller community in order to address their housing needs

Recommendation aimed at: St Legers Homes, DMBC

Consultation Process

Focus group participants attended meetings where the findings and recommendations of the report were discussed. The aim of these meetings was to ensure all key points from the focus groups had been captured accurately. Furthermore to check if participants felt the recommendations were a reasonable and proportionate response to the findings.

Each recommendation has been aimed at one or multiple health and wellbeing partners. Each partner was contacted and invited to attend a meeting to discuss the recommendations. Those unable to attend were given the opportunity to respond with written comments. This process included internal departments within DMBC. The aim of this consultation process was to ensure that recommendations were realistic and implementable. Changes to the recommendations were made according to the feedback received. This process has also fostered a sense of ownership of the relevant recommendations for partners and teams at DMBC.

The report was made available on the council website and social media pages for public consultation purposes. The public were asked to feedback their thoughts on the recommendations in the report. There were a small number of respondents. Generally there was a high level of agreement with the health issues highlighted within this report and the appropriateness of the recommendations. The public expressed concern that there needs to be careful monitoring of the implementation of recommendations to ensure change is seen.

Moving Forward

Action planning, implementation and monitoring are the next stages of this piece of work. The following stages of this are mapped out below;

Action Required	By Whom	By When
Report on current work taken to the Health and wellbeing board for approval of recommendations	Dr Victor Joseph	15th March 2018
Partner organisations to own relevant recommendations	Key Partner Organisations	15th March 2018
Update the Action Plan of the Health Inequalities working group to reflect roles and responsibilities of this group. This includes an update of responsibilities regarding oversight of implementation of BME work	Health Inequalities Working Group	April 2018
In co-ordination with partners develop and agree upon a detailed action plan for this piece of work including; - Indicators to be monitored in implementation - Timeline for actions, outcomes and monitoring - Priority of actions	Health inequalities working group, key partner organisations identified in report,	September 2018
Establish terms of reference for BME advisory group, agree on a recruitment process and advertise for roles	Dr Victor Joseph, Strategy and performance Unit	June 2018