

**Access to and
experiences of
health care by
ethnic minorities**

April 2024

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1. Introduction

This report has been produced by Healthwatch Tameside for [Tameside Inequalities Reference Group](#). The Inequalities Reference Group (IRG) aims to reduce inequalities in Tameside. The group meets on a quarterly basis, providing a forum for the sharing of ideas and thoughts on carrying out responsibilities under the Equality Act 2010 and the Public Sector Equality Duty.

While the group is not a decision-making body, it acts in an advisory role to the Tameside Health and Wellbeing Board, making recommendations to steer actions in addressing inequalities and providing constructive challenges.

This report aims to describe and explore the following:

- What are the experiences across various ethnic minority groups in accessing healthcare and during the healthcare process?
- How are their experiences at different points in the healthcare system – primary care, secondary care, mental health?
- How do experiences differ across intersections with other protected characteristics – gender, disability, religion?

2. About us

Healthwatch Tameside is your local health and social care champion. If you use GPs and hospitals, dentists, pharmacies, care homes or other support services, we want to hear about your experiences. As an independent statutory body, we have the power to make sure NHS leaders and other decision makers listen to your feedback and improve standards of care.

3. Executive Summary

This report sought to understand the experiences of people from ethnic communities accessing health and care services. Evidence was gathered from a wide range of national and local reports and articles, along with local focus groups held in Tameside. Reports on the Greater Manchester area or neighbouring boroughs were used where information did not exist for Tameside specifically.

Findings include:

- There are significant issues with data quality. Ethnic categories are not sufficiently nuanced and granular, combining many different cultures into broad categories. There are also challenges with the quality of data captured using those categories. In some areas, little data exists.
- There are well known health conditions that affect ethnic groups more than white groups such as diabetes and cardiovascular disease.
- Ethnic communities often live in areas of high deprivation, compounding poor health.
- Ethnic communities were disproportionately negatively impacted during the Covid-19 pandemic.
- People from ethnic communities are more at risk of social isolation as they get older.
- Refugees from other parts of the world such as Ukraine have additional needs that require trauma informed approaches and mental health support.
- Almost 6% of people in Tameside have a first language other than English.

There were common themes for challenges faced by ethnic communities in accessing health and care services:

- Reduced access to GPs is exacerbated for people from ethnic communities as they may have more challenges using online or telephone access.
- Lack of information provided in their first language; services do not follow the Accessible Information Standard.
- Difficulty accessing quality interpreting services for medical appointments.
- A lack of 'cultural competence' and a need for staff training in this area.
- Increasing digital access provides an additional barrier to services for many, as they are not provided in the first language of many people from ethnic communities.
- Access to the right services is even harder if you have both a disability or long-term condition and you are from an ethnic community.
- Ethnic communities are more likely to have delays in planned care and operations.

- Maternity services are frequently highlighted as not meeting the needs of women from ethnic communities.
- People from ethnic communities can be offered different treatment options such as pain management due to cultural stereotypes.
- People from ethnic communities are less likely to be included in clinical trials and research.
- There is a distrust of mental health services, evidence shows a disproportionate number of people from ethnic communities are held in secure mental health wards.
- People from ethnic communities are less likely to be referred for preventative services such as Improving Access to Psychological Therapies (IAPT)

The report makes conclusions and recommendations for further action.

4. Methodology

This report was composed of two components:

- A national and local literature review
- Focus Groups held in Tameside.

4.1 Literature Review

35 reports and articles were found to be within the scope of this project. They were drawn from a range of sources:

- National
- Tameside specific
- The Greater Manchester area

The insights from the literature review were divided into themes:

- National issues and insights
- Tameside issues and insights
- Primary Care
 - National issues and insights
 - Local issues and insights
- Hospital services
 - National issues and insights
 - Local issues and insights
- Mental Health
 - National issues and insights
 - Local issues and insights

These themes are developed further in the relevant sections of this report.

4.2 Focus groups

There were three focus groups held in the Tameside area:

Focus Group 1

BAME Memory Café at United Church, Hyde – Tuesday 12th September, 2pm.

Present were 9 members of the group, including two interpreters, who attend each week, as the members are from varying ethnic backgrounds. The seven members were aged between 50 to 65 and the interpreters were aged between 25 and 30. All are local women, 5 from the Bangladeshi community and 4 from the Pakistani community.

Focus Group 2

Healthy Hyde Women Only Luncheon Club at United Church, Hyde – Tuesday 31st October 12 noon.

Present were 16 members of the group, all female, including 13 from the Bangladeshi community, one person from the Pakistani community and one person from Spain, who all attend the ESOL class run by Healthy Hyde. One person is British Asian and acted as interpreter for the group when needed. This a role that this person takes on when other organisations visit this group. Some participants had a basic level of English and spoke for themselves with minimal language support. The person from Spain was confident using translation service on her phone if she needed to it to communicate with us. The age range was between 30 and 50.

Focus Group 3

Ashton Central Mosque – Wednesday 15th November 2023 at 11.45

Present were 5 people at Ashton Central Mosque. There were five women, all from Ashton and aged between 25 and 35.

The feedback from the focus groups is incorporated into the insights and findings for:

- Primary care
- Hospital services
- Mental health

The insights from the focus groups can be found in the relevant sections.

5. National Issues and Insights

The Kings Fund have utilised 2011 census data to give an overview of the health and social care issues for people from ethnic groups other than White British.

The 2011 census data uses categories of groups that include a wide range of cultures. For example:

- **The South Asian group** encompasses people from India, Pakistan, Bangladesh, Sri Lanka, Nepal, and Bhutan.
- **The Asian group** generally includes individuals from Southeast Asia.
- **The Black group** comprises people of African and/or Caribbean origin.

Health data primarily comes from health records. However, these records suffer from imperfect coverage and quality. These data limitations pose challenges in understanding health issues among ethnic minority groups. In response to the Covid-19 pandemic, NHS England is actively improving ethnicity recording in health records, and the government plans to introduce ethnicity recording in death certificates. These developments should give a deeper understanding of ethnic differences in health.

The data shows that there are key themes for ethnic communities:

- Ethnic minority groups (especially Pakistani and Bangladeshi) are more likely to report long-term conditions and poor health compared to White British individuals. The White Gypsy or Irish Traveller group reports the poorest health.
- Non-white groups were disproportionately negatively impacted by the Covid-19 pandemic.
- Rates of childhood obesity are higher among children in Bangladeshi and Pakistani groups.
- South Asian groups have the highest mortality from heart disease and develop heart disease at a younger age.
- More people have strokes in the South Asian population.
- Despite high levels of high blood pressure and diabetes (risk factors for heart disease and stroke), Black groups in the UK have a significantly lower risk of heart disease compared to the majority population.
- Black groups are more likely to have high blood pressure and stroke and experience strokes at a younger age.
- Obesity levels are higher in Black and South Asian groups.

- The risk of developing diabetes is up to six times higher in South Asian groups than in white groups and Black groups are up to three times more likely to develop diabetes.
- Screening rates for breast and cervical cancer are lower among women from ethnic minority groups, especially South Asians.
- South Asians also have lower rates of bowel cancer screening.
- Some of these differences may be associated with higher levels of deprivation among ethnic minority groups. Asian and Black households have a higher likelihood of living in low-income households.

(Raleigh, 2023)

The NHS Race & Health Observatory undertook a Rapid Evidence Review in 2022. The review found that there were widespread ethnic inequalities in healthcare in the areas reviewed, as well as ethnic inequalities present for the NHS workforce. There were common experiences for ethnic minority people within NHS services, and issues with the availability and quality of clinical data, NHS datasets and data collected for research purposes. Some of the evidence that was reviewed was poor quality and there were some ethnic minority groups for whom there was no research conducted on their experiences at all. Key issues the review found were.

Racism and Discrimination:

The report highlights that racism, both structural and interpersonal, plays a significant role in creating barriers to healthcare access for ethnic minority groups.

Mental Health Services:

There is evidence of ethnic minorities facing difficulties in accessing mental health services, with a lack of trust and fear of discrimination being major deterrents.

Maternal and Neonatal Healthcare:

Ethnic minority women experience challenges in maternity care due to poor communication, lack of trust, and cultural insensitivity from healthcare providers.

Digital Inclusion:

The shift towards digital healthcare has raised concerns about ethnic minorities' access to these services, with issues such as digital literacy and mistrust of data usage by government agencies being highlighted.

Health Services' Policies and Practices:

- **Implicit Bias:** Health providers may unknowingly harbour biases that affect their clinical decisions. These biases can lead to differential treatment based on race or ethnicity.
- **Cultural Competence:** Insufficient cultural competence training for health professionals can result in misunderstandings, misdiagnoses, and inadequate care for ethnic minority patients.

- **Language Barriers:** Inadequate language services hinder effective communication between patients and providers, impacting diagnosis, treatment adherence, and overall health outcomes.

Health Services Quality and Treatment:

- **Disparities in Treatment Options:** Ethnic minorities may receive different treatment options compared to their white counterparts. This can be due to historical biases, stereotypes, or assumptions about pain tolerance.
- **Pain Management:** Studies show that ethnic minorities are often undertreated for pain, leading to unnecessary suffering and compromised recovery.
- **Clinical Trials and Research:** Historically, ethnic minorities have been underrepresented in clinical trials, affecting the use of medical research findings for diverse populations.

Data:

The report found that there was:

- poor ethnicity data recording in NHS clinical records as well as a lack of linkage across clinical datasets at a national level.
- a lack of good quality national data on the use of NHS services by ethnic group, age, gender and other important demographic and socioeconomic variables, and adjusted for level of ill health.
- a severe lack of high-quality interpreting services.
- deep distrust of NHS services and professionals (rooted in experiences of racism) by many different ethnic minority groups that deterred seeking help; and
- a lack of high-quality research studies that were designed to investigate the mechanisms underpinning ethnic inequalities in healthcare in sufficient detail.

(NHS Race & Health Observatory, February 2022)

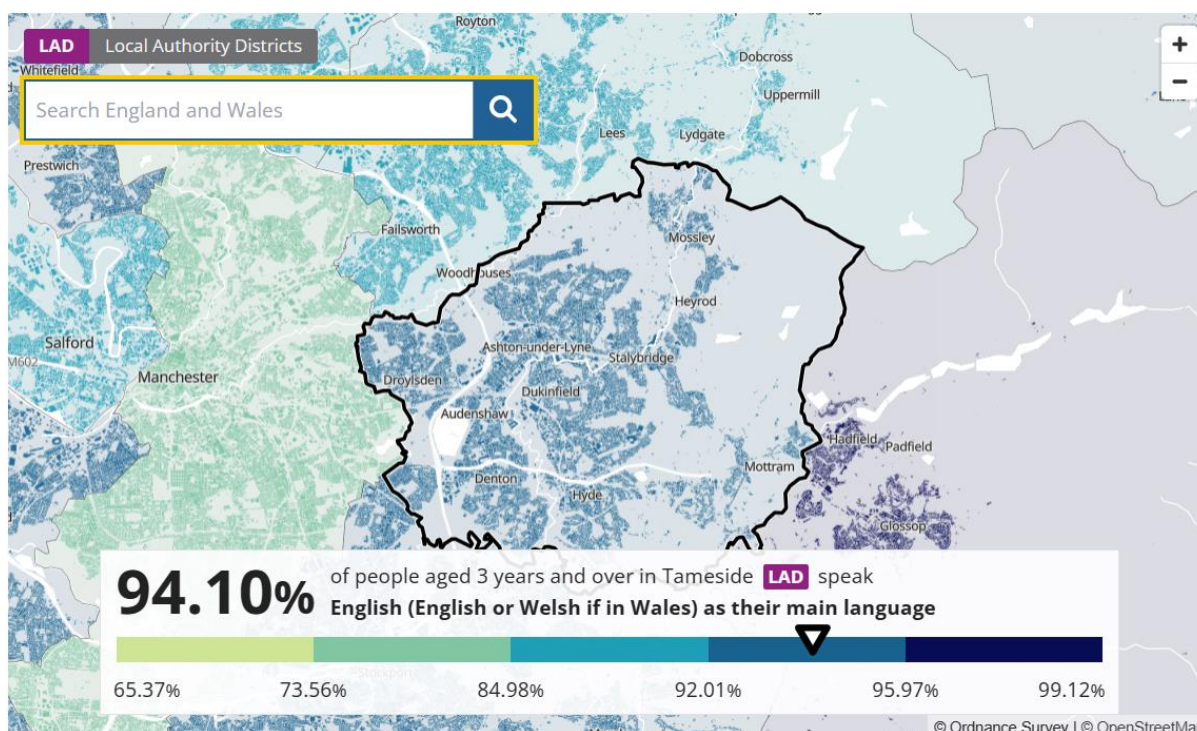
A GP, Dr Oluwatosin Ajayi (Sotubo), reviewed the issue of structural racism in the NHS and found that despite the NHS Workforce Race Equality Standard (WRES) being established in 2015 for organisations to monitor staff experience, BAME staff still struggle with the consequences of inequality and racism. There is a lack of diversity and BAME representation at an NHS trust board/executive level. He felt eliminating institutional racism should be a priority and senior positions in the NHS at both national and local level should reflect the population and the society it serves. ((Sotubo), 2021)

5.1 Language

The Office for National Statistics provide the analysis on languages spoken across the UK:

- In 2021, 91.1% (52.6 million) of usual residents, aged three years and over, had English (English or Welsh in Wales) as a main language (down from 92.3%, or 49.8 million, in 2011).
- In 2021, a further 7.1% (4.1 million) of the overall population were proficient in English (English or Welsh in Wales) but did not speak it as their main language.
- The most common main languages, other than English (English or Welsh in Wales), were: Polish (1.1%, 612,000), Romanian (0.8%, 472,000), Panjabi (0.5%, 291,000), and Urdu (0.5%, 270,000).
- The largest increase nationally was for people who specified Romanian as a main language, who accounted for over 0.8% of usual residents in 2021 (472,000 people), up from 0.1% (68,000) in 2011.

In Tameside, 94.1% of people spoke English as their first language:



The national figures indicate that the percentage of people in the UK whose first language is not English (or Welsh in Wales) has increased.

Although lower than the national average, almost 6% of people in Tameside have a first language other than English. (Office for National Statistics, 2022)

The Dr Ajayi (Sobuto) report highlights:

- **Language Barriers** are significant in affecting healthcare access for ethnic minorities. Non-English speakers face difficulties with administrative staff;

informal translation is common but not ideal. Language barriers can lead to longer GP consultations without extra allocated time, causing strain.

- **Interpreting Services:** Formal interpreters are recommended to ensure quality care and avoid informal translation. The General Medical Council requires that patients' language needs are met. There are different models in primary care, with some using commercial and others not-for-profit services. There is also little evidence of user experience feedback being collected on satisfaction with interpreting services. ((Sotubo), 2021)

5.1.1 Interpreting Services

Healthwatch England commissioned six Local Healthwatch across England to undertake an analysis of patients' views of interpreting services. In total, 109 people from diverse ethnic minority communities, including people who identify as Arab, Bangladeshi, Chinese, Polish, Ukrainian, Somalian and Honduran, participated in the research. Additionally, 38 staff members working in different healthcare settings took part in the research to share their experiences. The barriers they talked about were:

Poor availability of interpreting services

- Access to an interpreter can be more difficult for a face-to-face appointment than a phone appointment because staff need to book the interpreter in advance. Several participants pointed out that the pandemic has made accessing an interpreter for remote and in-person appointments more difficult. People found it more challenging to get an interpreter for GP than for hospital appointments.
- As a result, some made their own arrangements. This could take time and may not be free of charge. One participant asked someone from their community to help and paid them for their time.
- Difficulties in making arrangements might put people off seeking help from the NHS. The report heard about alternative solutions, such as asking relatives from their home country to send them medicines.

Limited access to urgent care services

- Access to urgent care services can be challenging if services don't record communication needs. For example, calls to NHS 111 can be much longer. Several participants stated that they often do not understand the information they hear when calling NHS 111. Some end up in A&E, where they struggle again to express their concerns.

Quality of interpretation

- When interpretation is provided, the quality and suitability of these services sometimes need improvement. Healthwatch heard about interpreters not understanding medical terminology or speaking a dialect sometimes so distinct that it is like another language.

- As a result, patients have felt obliged to rely on family or community members to help with their translation needs. This puts them in a position where they feel uncomfortable or unable to share private information with their care providers, as they do not wish to share these confidential details with members of their community.

“I don't know if they actually understand me because I'm Syrian. They bring an Iraqi, a Moroccan, Tunisian [interpreter]. The dialects are different, and that's a struggle.” (Syrian woman who spoke to Healthwatch Reading)

Lack of translated information in other languages

- People who cannot read English find it hard to get written information about their conditions or medication in their first language.
- Healthwatch also heard that translated information that has complex terms without explanation may not help people understand what action to take. For example, a Yemeni woman mentioned that the information she had received had Arabic words that were difficult to understand.
- Without access to translated information, people take risks by self-diagnosing or self-medicating without consulting their doctors.
- Access to information in other languages was particularly challenging during the pandemic. Some of the participants said they used social media to search for information. This might mean that they got inaccurate and misleading information about keeping themselves safe.

Low awareness of communication support

- Due to a lack of available information, people with little or no English may not be aware of language interpretation services that are available to them. Several people the report spoke to didn't know they could ask for help for their communication needs. As a result, they had never used NHS interpreting services. Moreover, those aware knew of such services at hospitals but not at GP surgeries.

“I wasn't aware that I can request support around interpreting. I only thought that this is available through the hospital and only if they think it is necessary. I thought it's only for midwifery because the only one who brought me an interpreter was the midwife. Often my husband had to skip college to come with me to appointments.” (Arabic woman who spoke to Healthwatch Hackney)

Issues around support from GP practices

- GP services are the initial point of contact for patients. However, it is not clear from the findings whether they receive any training to identify and support people with limited or no English.

- Consequently, they may not record or misrecord a people's language needs at the beginning of their healthcare journey. As a result, they may overlook a person's needs, affecting access to treatment and other services.

Services not being joined up.

- The research highlighted inconsistencies in the type and quality of health services' software systems. Different trusts and care systems use various programmes that don't communicate. As a result, patient information is not always shared effectively, and essential details about language challenges are missed or overlooked.

Inadequate staff support

- The staff know that they need more support to help patients with little or no English language skills. But some services don't have the right processes to identify and help patients with language needs. This means that staff are unprepared to assist patients who speak little or no English.
- Software and systems across individual services don't always provide a prominent place to record patients' language needs. As a result, staff may record these details on an 'as and when' basis.

Funding and costs

- Many healthcare staff recognise the importance of language support and want to help patients but feel constrained by ever-reducing budgets for support.
- Consultations for those who require language support are typically longer, more complex, and more costly. Trusts are often charged by the hour for interpreters, which can be expensive when there is no clear indication of how long appointments will last. It can discourage them from allocating funds towards interpretation services.
- Some staff mentioned they could come under pressure if trusts feel they "over-use" interpretation services. On these occasions, departments can be flagged for using interpreters too frequently or asked to make sure they only use interpreters "if they really need to".

(Healthwatch England, 2022)

In 2023, Healthwatch Bedfordshire engaged with:

1. The Gypsy and Traveller community in Bedford Borough
2. Women from ethnic minority groups living in areas of multiple deprivation in Bedford Borough including West African, Bangladeshi and Bulgarian.

Three overarching themes appeared repeatedly in the responses given by participants in each of the groups, across all the questions discussed:

1. **Interpreters**
2. **Literacy**

3. Understanding of culture

When these three issues combined, there was a palpable sense of several barriers with the responsibility for overcoming them being placed firmly on the individual.

All the women said that they could become overwhelmed with information. Only one of the women in the Bangladeshi group said that she was able to read or write in English, whilst only one woman in the Bulgarian group could speak, read, or write in English. All of the women in these two groups said that they needed support from an Interpreter. Most participants said that health professionals will sometimes use words they do not know. Therefore, even with an Interpreter, they do not understand what is being explained to them. The NHS 111 service was mentioned specifically by Bengali women in the Bangladeshi group. Nine out of ten of them said that they were not able to use this service and suggested that there needs to be a way of choosing which language to speak in.

Almost all of the Gypsies and Travellers who participated in the study described literacy as a barrier to meaningful communication about their health or social care. About half described it as the most important barrier, using terms such as struggle and embarrassment.

Cultural competency includes an understanding of the visible differences between communities such as dress and the religious significance of events such as Eid and Diwali, and some less visible differences such as tone of voice. Participants in this study describe negative experiences that have arisen due to a lack of cultural understanding and competency, leading to discrimination and unequal treatment. Institutional racism, arising from systems, structures or expectations established within organisations, is not isolated to discriminatory incidents but also manifests in practices which exclude sections of the community. This includes 'habits of thought' which are not examined deeply. (Healthwatch Bedford Borough, 2022/23)

5.2 Disability

The Local Government Association (LGA) reviewed existing evidence of people using social care services in 2023 to develop a profile of people with disabilities across the UK.

- The majority (61.5%) of the 14.6 million people with disabilities in the UK were over 50 years old.
- The gender representation in this age group was almost equal, with 55% being female.
- 9% of the people with disabilities were under 19, representing a 9% incidence of disabilities among the general population of this age group. The majority (6%) of the individuals in this age group were male, while in the entire disabled population, females had a small majority (56%).
- Mixed white and black Africans were the most likely to use mental health, learning disabilities, and autism services in 2021.

- The most common disability in 2021 was mobility impairment which affects 22.97% of the disabled individuals, or 6.8 million people.
- The second most common impairment was stamina/breathing/fatigue (16.22%),
- This was followed by mental health (14.5%).
- 11.15% of individuals suffered from dexterity impairments.
- Up to 2% of the UK population in 2020 was autistic, or 1.8% of children in England in 2021, with autism diagnoses increasing significantly over the past two decades.

Disabled people called for social care services to consider their identities when providing support. It was suggested that services need to better understand the diversity of identities and experiences held by disabled people as well as how multiple identities can interact with each other. Service users often experienced cultural identities to be dynamic and wanted services to facilitate developing more complex identities as well as meet basic language and cultural needs. (Local Government Association, 24 Mar 2023)

5.2.1 Learning Disability

Research by the Race Equality Foundation on people from ethnic groups with a disability found:

- People with a learning disability from Black, South Asian (Indian, Pakistani or Bangladeshi heritage) and minority ethnic backgrounds face shorter life expectancy triggered by poorer healthcare access, experience and outcomes.
- The average age of death for people with a learning disability who are from an ethnic minority is 34 years, just over half the life expectancy of white counterparts, at 62 years of age. Of those with a learning disability who die in hospital, 51% from ethnic minority groups have a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) recommendation, compared to 73% for those who are white.

(Race Equality Foundation, 2023)

5.3 Covid-19 Pandemic

A report from the Commission on COVID-19, Ableism and Racism published in 2023 shows that major failings occurred in how the government communicated with disabled people from Black, Asian and minority ethnic groups during the pandemic.

- The commission scrutinised governmental policies and pandemic responses that evidenced systemic racism worsened outcomes for Disabled Black, Asian and minority ethnic people.

- This is on top of medical racism, housing and wealth inequalities, all of which lead to poorer qualities of life, especially those at the intersections, such as Disabled people of colour.
- The government said that COVID-19 was only serious for 'vulnerable' people including Disabled BAME people. However, ministers did not try to understand why that was or to address this increased risk. Disabled BAME people also experienced increased discrimination and disruption when accessing health and social care services.
- The report states that these failures led to disabled people who are Black, Asian and from minority ethnic communities feeling:
 - Isolated from the wider community and their own families, unable to access support.
 - Confused about whether it was safe to go out. This was because they were labelled 'vulnerable' and were unclear when social isolation applied and stopped.
 - Discriminated against because of existing stigma linked to disability and race, exacerbated by being labelled as 'vulnerable' without the government explaining why.

(Disability Rights UK, 2023)

In 2021 Healthwatch Manchester wrote the report, 'Covid-19 what's changed?' to understand how access to services had improved in the second year of the pandemic. It repeated an approach from 2020 to compare results across three groups:

- Group A – general public.
- Group B – people for whom English is a second language, including Chinese and Urdu speaking communities in Manchester.
- Group C – people with a disability, including people from the Deaf community in Manchester.

There are two notable changes which arose from the comparison of the two survey results. Firstly, in group B there was an increase of 48% in the number of respondents who reported feeling well-informed about the risks posed to their health in comparison to our earlier survey. Secondly, group C recorded a drop off 26% in those who felt well-informed, with only half of our group C respondents responding positively.

The comments received from group C respondents stated that the information was not accessible, as they needed it to be provided in an easy read format, whilst others said that online only information was not accessible due to a lack of internet access.

The report concluded that:

- local community and culturally focussed organisations were the most trusted source of COVID-19 safety information in Manchester for these three communities.
- There was a lack of readily accessible information around COVID-19 safety for people from vulnerable communities. These include people for whom English is not their first language and for people who require extra support in understanding and adopting safety practices.
- Across all of the groups and communities, the most frequent source of information and support had been their local pharmacy. It was clear that pharmacies are vital community assets when it comes to providing ready and accessible information for local people.

(Healthwatch Manchester, June 2021)

6. Tameside & Greater Manchester

The registered population of Tameside according to the 2021 census is 231,063 usual residents. There are more residents living in Tameside than there are patients registered with a Tameside GP practice, this means around 5% of residents are registered with GPs outside the Tameside boundaries. More people now live in Tameside than at any time in the past, with population projections estimating that this will continue to increase over the next 20 years.

The ethnic composition of the Tameside population is also changing, with the census showing that 14% of the local population are from an ethnic minority group. (Tameside Metropolitan Borough, 2023/24)

Life expectancy is improving in Tameside; however, people in Tameside still have overall worse health and lower life expectancy than England. The top causes of this difference are deaths from heart disease, cancer and respiratory disease.

Population estimates illustrate that 80% of the Ashton neighbourhood's population is of 'White' ethnicity, compared to 91% average for the borough. The Ashton neighbourhood has a much higher than average proportion of 'Asian or Asian British' population than the Tameside average (16% vs. 6.2%), with slightly higher populations of 'Mixed', 'Black and 'Other' ethnic groups. Ashton St Peters in particular has a larger BME population than the Tameside average.

Cardiovascular Disease (CVD) is a major cause of death in ethnic minority groups particularly those of South Asian heritage. The Tameside electoral wards with the highest mortality from heart disease include Ashton's St. Peters.

The Hyde neighbourhood has a higher than average proportion of 'Asian or Asian British' population than the Tameside average (9% vs 8%), with smaller populations of 'Mixed', 'Black, or Black British', 'Chinese' and 'Other' ethnic groups than the Tameside average, and Hyde Werneth has the highest number of Bangladeshi residents of any ward in Tameside, accounting for 40% of the borough's total Bangladeshi population. Pakistani and Bangladeshi communities in Tameside have a young age profile and it is expected that the older population will increase significantly in the future, significantly impacting on this locality. (Tameside Metropolitan Borough Council, 2022). The top five languages spoken after English across Tameside schools are Urdu, Bangla, Polish, Punjabi and Arabic. (Tameside Metropolitan Borough, 2021/22)

6.1 Social isolation

Social isolation has a significant impact on physical and mental wellbeing and a review across Greater Manchester highlighted that the risk of social isolation varies amongst minority ethnic groups:

- Individuals from minority ethnic backgrounds are more likely to experience health, social, and economic inequalities, thereby increasing the risk of social isolation.
- BAME individuals are more likely to experience discrimination and racism over the course of their lives. This may increase the risk of social isolation by limiting opportunities for social and economic participation.
- Cultural and community organisations can play a bridging role by facilitating access to services and raising awareness about ways of preventing social isolation.

(Lewis, April 2018)

6.2 Activity

Sport England, in their 'Sport for all' report, highlights the ethnicity gap in physical activity and sport across the country. The report highlights how deep-rooted inequalities mean people from black and minority ethnic backgrounds are far less likely to be physically active.

As well as being less likely to be active, people from BAME backgrounds are also less likely to volunteer within sport and physical activity. The analysis shows that to address long term inequalities within sport and physical activity, we need solutions built out of an understanding of:

- The diversity within and between different Black, Asian and Minority Ethnic adults and children in England and their preferences
- The compound effect of multiple demographic characteristics
- The impact of the whole system on behaviour

(Sport England, January 2020)

In Greater Manchester, since November 15-16, South Asians have seen the greatest increase in inactivity (+10.8%). White British and White Other have also all seen an increase in inactivity, but to a much smaller degree (+0.5%, and +0.1% respectively). Whilst those who identify as Black have seen a decrease (-2.4%) there has been significant fluctuation in rates of inactivity. Other ethnic groups and those who identify as Mixed or Chinese have also seen a decline in inactivity (-9.7%, -8.7%, and -4.9%). (Greater Manchester Sports Partnership, April 2022)

6.3 Ukrainians

A needs assessment was completed during January to March 2023, covering the whole of the Northwest of England showed that there are Ukrainian refugees in every local authority in the Northwest, but the numbers in each authority are relatively low. The report demonstrates there are more refugees in Cheshire East, Cheshire West and Chester, Cumbria, Lancashire and Manchester with higher densities in Blackpool and Trafford.

Key issues for Ukrainian refugees are:

- Musculoskeletal, skin and respiratory complaints.
- mental health concerns and substantial trauma directly and indirectly caused by the war, needing a Trauma Informed Approach.
- The trauma is also having an impact on maternal health and resulting in early births and poor maternal outcomes.
- Dental health with limited access to a dentist and large numbers reporting experiencing dental pain.
- Refugees have reported experiencing language and cultural difficulties in accessing and receiving treatment and have found the health care system difficult to navigate. Ukrainians are not accustomed to the gatekeeper type role of the GP.
- Family separation, increasing the risks of isolation, but good community networks are being developed.
- As the war continues, refugees state that fear of finding and affording a longer-term housing of their own is beginning to cause anxiety.

(Office of Health Improvement & Disparities (North West), May 2023)

7. Primary Care

7.1 National

The Kings Fund analysis found that access to primary care health services is generally equitable for ethnic minority groups, but this is less consistently so for dental health care. However, people from some ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than their white counterparts. (Raleigh, 2023)

The NHS Race & Health Observatory rapid review found some evidence that ethnic minority participants might use digital access less frequently. The studies indicated how this may be out of mistrust of intended uses of data by government agencies. It was also suggested that older ethnic minority people had a lack of access to digital devices, a lack of digital literacy or digital applications not being made available in languages other than English.

There was lower use of NHS 111 services by most ethnic minority groups compared to the White British group, and ethnic inequality in referral to urgent and emergency care services by NHS 111 for Bangladeshi people, particularly for those living in deprived areas.

Compared with their White counterparts, ethnic minority people were less satisfied with telephone triage systems in GP surgeries, were less likely to use online services and less likely to have used electronic health records. (NHS Race & Health Observatory, February 2022)

Healthwatch England undertook analysis of 1518 people's experiences of GPs making referrals to other services in 2022. Those who reported having a poorer experience were more likely to be younger, of ethnicity other than white British, neurodivergent, less well off or lower educated. (Healthwatch England, 2022)

The Care Quality Commission (CQC) State of Care 2022/23 report found that people from ethnic minority groups with a long-term condition stated that they had found it increasingly difficult to meet with their healthcare provider. For example, follow-ups were less regular than previously and there was an emphasis on them self-monitoring their condition. They also noted a difference in how services manage appointments and reported repeated delays and cancellations, as well as miscommunication about missed appointments.

Getting through to someone at their GP practice on the phone was an improved experience for white patients and a worse experience for patients from ethnic minority groups.

People from ethnic minority groups who have a long-term condition had noticed an increasing use of telehealth but expressed a preference for in-person appointments where care feels more human and person-centred. Furthermore,

some demonstrated how using technology could increase inequalities in access to care. For example, a patient with an autoimmune condition said their doctor was unable to see a rash on their skin through the video call so put that down to their skin colour. Some felt 'talked down to' about their treatment, and not treated as individuals. They also said that decisions were made about their care without consulting them and that asking for things which were best for them was difficult. (Care Quality Commission, October 2023)

A study into regular reviews of medications found that, despite being more likely to report a long-term illness that requires medication when compared to their white counterparts, individuals from ethnic minority communities are less likely to engage with regular medication reviews, with inequalities negatively affecting their access. It found:

- Multilingual medication labels are needed for ethnically diverse populations.
- Face-to-face communication was needed for building trust and relationships and acknowledged that the COVID-19 pandemic further exacerbated communication issues, where mask-wearing was perceived as a communication barrier for non-native English speakers.
- Peer support networks in religious and community-based settings and community WhatsApp® groups to overcome accessibility barriers to medication review services.
- Cultural competence training should be implemented in pharmacy curricula to widen knowledge of cultures within the populations they treat.

(Robinson, 2022)

7.2 Local

Focus Group feedback:

Focus Group 1, local women, 5 from the Bangladeshi community and 4 from the Pakistani community, felt that primary care services were much more difficult to access since the Covid-19 pandemic. It was also felt they were not culturally sensitive; they had lost their relationship with their GP surgery, and they were unhappy with the service provided.

Attendees preferred to use the telephone or book appointments in person. They felt online systems difficult as not everyone had a smartphone or access to a computer. Not everyone had someone who could help them with online access, and for those who did they felt this took away their independence. This also caused issues with the use of text messages from the GP practice and not attending appointments when they didn't receive the message.

GP Practices need to be more culturally sensitive to ethnic minority populations and to be aware when someone may have difficulties with spoken and written English. Dialect was also mentioned as an important consideration, even when

interpretation is available. They would also like to see better access to face to face appointments with a GP and for waiting times to be addressed.

Some ladies commented that they are always being asked to give feedback and help with projects like this, but nothing ever seems to change. They would like to be told of the outcome of this one please.

Below is the feedback from Focus group 2, 16 females, including 13 from the Bangladeshi community, one person from the Pakistani community and one person from Spain:

Tell me about your general experience of primary care?

- I can't get GP appointments, so end up going to the hospital for treatment.
- I can never get hold of a dentist.
- Much has gone online now, so I struggle to get medical appointments.
- I have good English skills and often take my Mum and my Nan to appointments, but I am not always allowed to interpret for them, which seems irrational, as I would be there to help them anyway.
- Another respondent pointed out that many people, like herself do not have anyone to go with them to appointments and if their language skills are not good, they have no help at all.
- One lady went to her GP for help and was told she needed a blood test. This meant making another appointment for the test, which took four weeks, during which she was still suffering from the original problem.
- Some respondents complained that they had rung for a GP appointment and when they arrived, found that they were instead booked to see a Nurse Practitioner or a Trainee doctor, which they had not been aware of at the point of booking the appointment.
- Some people reported waiting many weeks for a routine appointment, including an asthma review.
- Although it is better to see your own GP, I don't mind seeing another clinician – at least you are being treated and not waiting longer for help.

What was your experience of trying to access primary care?

- Difficult – you have to ring at a certain time in the morning and can be redialling for a long while or waiting in a queue, only to be told when you get through that there are no appointments left and you have to try again the next day.
- They keep saying I should go online but I haven't got a way to do that and no-one to help me.

What has changed in the way your GP operates?

- This system of telephoning for appointments which are all allocated at once does not work.
- I keep being told to go online now but I haven't got access to it.
- At my surgery, I do get offered telephone appointments now rather than face to face but I am ok with that.
- I don't use online services, I ring at 8am and am usually lucky and get an appointment with my choice of GP.

What was your experience of these changes?

- I don't like them and never get to see my GP.

Did you do anything to try and resolve the issue or to complain? If so, what was the outcome?

- I don't want to make complaints.

What advice would you give to policymakers about how to support people like you struggling to access GP services?

- They should prioritise better, for example children and urgent care services.
- They should make sure that people in pain can be seen more quickly.

Any other comments?

- The Walk-in Centre was better when it was on Old Street and not part of the hospital. I understand that it's better if people need to be admitted quickly but in general, the waiting times are now longer than when it was based at the Primary Care Centre. You could be treated fairly quickly there for most things.
- Dentist – I can wait up to a year now for an appointment, used to be seen more often.

Questions to explore for those who were able to access appointments.**What kinds of appointments did you have? (Telephone consultation, video consultation, in-person)**

- I haven't seen my GP for one and a half years; it's been all telephone appointments.
- I did have a video call for a bruised knee, and this worked well for me.

Were you given the option to choose between a remote consultation or a face-to-face appointment?

- Not everyone reported having this option, but one surgery apparently does offer it.

Would you have liked the option?

- Some respondents would have liked a choice but didn't get the option.

If you experienced a telephone consultation, how did you feel about it? What were the positives/negatives? Did you have any issues using the telephone to talk to your health professional?

- One person said she was happy to have telephone appointments, but other people may struggle with language barriers.
- I prefer face to face but a telephone appointment is better than nothing. At my surgery, no interpretation is provided for general things but for some specific things, I get asked to call back for an appointment with an interpreter provided.

If you experienced a video consultation, how did you feel about it? What were the positives/negatives? Did you have any issues with the technology?

- Only one person reported using a remote consultation and she is fine with technology.

How did the experience of a remote consultation affect the quality of the care you received?

- Only one person reported using a remote consultation and she did not think it had affected the quality of care received.

Was there anything that would have improved your experience?

- Only one person reported having a video consultation and she was happy that it had saved her going into the surgery.

Could any additional support have helped you to access a remote consultation?

- No, I prefer to see someone face to face.
- I know that there would be help from someone to use the technology but that feels intrusive – I want to speak to someone directly and on my own if I can.

If given a choice, would you have wanted a remote consultation, or would you have preferred to have a face-to-face appointment?

- I would always prefer a face-to-face appointment (most respondents indicated this)

If you would have preferred a face-to-face appointment, why is that?

- I think it is better to be seen physically to be diagnosed.
- It is more personal to see someone.

Any other comments?

- I prefer to go in and see my GP and can always ask for a female doctor if needed.

Below is the feedback from Focus Group 3, five Muslim women, all from Ashton and aged between 25 and 35:

Tell me about your general experience of primary care?

- We all attend GP surgery in Ashton and the surgery isn't too bad.

What was your experience of trying to access primary care?

- I don't really know the doctors but have seen one when I needed to.
- You have to phone the surgery or go in early in the morning.
- They have mentioned online but I don't want to use that and there are other ways.

Tell me about your general experience of Hospital services?

- I have been to Tameside Hospital and not really had problems but there isn't always an interpreter and sometimes no female doctors available.

Tell me about your general experience of mental health services?

- Only one of the groups reported using or needing mental health services. She had been referred to the Talking Therapies service and was still getting some help from them.

What has changed in the way your GP operates?

- It has joined up with another surgery but apart from being a bit difficult to get through on the telephone sometimes, it's no different.

What was your experience of these changes?

- More time spent on the phone and not seeing the same doctors.

What advice would you give to policymakers about how to support people like you struggling to access GP services?

- More staff and more appointments needed. Keep notes on people who need interpretation, so they do not have to ask every time.

What kinds of appointments did you have? (telephone consultation, video consultation, in-person)

- Telephone appointments mainly but you can see someone in-person if the doctor decides it is best.

Were you given the option to choose between a remote consultation or a face-to-face appointment? Would you have liked the option?

- No, not given options and do not want to use video.

- I would prefer to see a person.

If you experienced a telephone consultation, how did you feel about it? What were the positives/negatives? Did you have any issues using the telephone to talk to your health professional?

- It is ok.
- Telephone appointments are not a problem for me.

Could any additional support have helped you to access a remote consultation?

- No, I don't want to use technology.
- I am not confident speaking on video.
- I would have to have someone to help me.

If given a choice, would you have wanted a remote consultation, or would you have preferred to have a face-to-face appointment?

- Face to face (general consensus)

If you would have preferred a face-to-face appointment, why is that?

- Easier to understand and be understood.
- I do not want to use remote methods.

Any other comments?

- Generally, these interviewees expressed that they were happy with their GP surgery.

7.3 Accessible Information Standard

From 1 August 2016, all organisations that provide NHS care and/or publicly funded adult social care have been legally required to follow the Accessible Information Standard (AIS). The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. [NHS England » Accessible Information Standard](#)

Healthwatch Manchester undertook a series of visits to local pharmacies in 2023 to test their compliance with the Accessible Information Standard. In total they visited 23 pharmacies across Manchester and found most had no knowledge of what the AIS was and hardly any provided access to a BSL relay service such as Sign Video or provided Large Print Materials or Yellow and Black labelling on their products for visually impaired service users. (Healthwatch Manchester, 2023), (Healthwatch Manchester, 2023), (Healthwatch Manchester, 2023), (Healthwatch Manchester, 2023), (Healthwatch Manchester, July 2022)

Healthwatch Manchester was also commissioned by Healthwatch England to review the integrated care arrangements for two specific groups of people:

(a) people from the South Asian community who have diabetes. They interviewed 13 Men and 7 women with diabetes.

(b) black men with multiple health conditions, including recent experience of cancer care (persona 4). They interviewed six men with cancer.

For the local black men who are living with multiple health conditions, including recent experience of cancer services they found:

- All expressed a positive relationship with their current GP and cited a big difference having a GP from the same community.
- Varied experiences with hospital and other services.
- More focus was required on mental health and wellbeing services.

For the members of the local South Asian community who have diabetes they found:

Generally, the participants reported being quite satisfied with the way the different services worked together but there were concerns about information sharing and concerns about a fragmented system.

When asked how their GP or local community services supported them, they found:

- Little information seems to be shared about the services that are available.
- Little focus on culturally appropriate services.
- Inadequate signposting.
- Poor awareness and accessibility of community services, such as dietary and exercise services. For those who had been able to access such services, they had only found out about them by conducting research themselves and raising this with their healthcare professionals, rather than the other way around.

(Healthwatch Manchester, August 2021)

8. Hospital Services

8.1 National

The CQC State of Care 2022/23 survey of patients using emergency departments showed that fewer patients from ethnic minority groups with a long-term condition reported that care and support was available when they needed it after leaving A&E.

Respondents also spoke of a lack of follow-up from their healthcare professionals. They felt that in instances of lifelong conditions, there should be greater emphasis on health care delivered in the longer term.

As well as a lack of lived experience, a lack of cultural competency was also seen as being a barrier to receiving good-quality care. A South Asian man with long-term conditions emphasised the need for better cultural awareness so that care plans are complete and appropriate:

“The lack of cultural competency in service design and provision is clearly an issue. How can you prescribe a care plan for people that you don't understand”.

8.2 Maternity

The Kings Fund reported that more than one-quarter (28 per cent) of the 595,300 babies born in England in 2021 were to mothers of non-white ethnic minority origin. Compared with the white group, the rate of women dying in the UK in 2018–20 during pregnancy or up to 6 weeks after the end of their pregnancy was 3.7 times higher in the Black group, and 1.7 times higher in the Asian group. Deprivation and pre-existing medical problems are significant risk factors for maternal mortality.

Although stillbirth and infant mortality rates in England and Wales have fallen in all ethnic groups since 2007, they remain higher among ethnic minority groups. They are highest among babies from the Pakistani and Black groups. The causes of infant mortality differ between ethnic groups. Again, deprivation is a significant risk factor: compared with white groups, higher proportions of mothers from ethnic minority groups, especially Black groups, live in more deprived areas.

The NHS Race & Health Observatory review found poor communication between women and providers was a prevalent theme. For women without English language skills, the lack of accessible and high-quality interpreting services seems to be a common issue. But communication can also be compromised for British-born ethnic minority women, and migrant women who can speak English. A lack of trust, insensitive behaviour, lack of active listening by providers, and failure to

bridge cultural differences, can also impact negatively on communication for these women.

A consistent theme was women's experiences of negative interactions, stereotyping, disrespect, discrimination and cultural insensitivity. System-level factors, as well as the attitudes, knowledge and behaviours of healthcare staff, contribute to some ethnic minority women feeling 'othered', unwelcome, and poorly cared-for.

The report also found that quantitative data on ethnic inequalities in access to antenatal booking appointments, Caesarean delivery, or breastfeeding support, is patchy and inconsistent. (NHS Race & Health Observatory, February 2022)

The CQC State of Care 2022/23 report heard from midwives who said:

- Midwives from ethnic minority groups say that care for people using maternity services is affected by racial stereotypes and a lack of cultural awareness among staff.
- Midwives from ethnic minority groups described a 'normalised' culture where staff tolerate discrimination from colleagues, and say they are less likely to be represented in leadership and managerial roles.
- Some staff 'not bothering' to try and communicate effectively with people who don't speak English, to actively targeting people for worse treatment.
- Even where women and other people using maternity services from ethnic minority groups can speak English, they are less likely to be listened to than people in White ethnic groups.

Midwives stated that there was a lack of willingness among some colleagues to use interpreting and translation services. Despite these services being generally available, they are not being used consistently, as it is seen as taking too long, or not worth bothering with – especially in less critical situations, such as a routine appointment:

"We have access to the interpreters, but no-one is picking up the phone to use them. It takes longer to use the interpreter, so people are not wanting to do it."

Some maternity staff also had misconceptions around bodies – midwives interviewed reported hearing the following said by colleagues, including senior colleagues:

- 'You have an African pelvis.'
- 'Black women have thicker skin, so they are less likely to have a tear after delivery.'

- 'You are African, you are tough – you don't need pain relief, you get on with it.'

There was a lack of knowledge or interest in conditions more common to some ethnic minority groups:

- "If I bring up fibroids or sickle cell, those are conditions that affect more ethnic minority women, and I find that [staff] don't know as much about them – and those study days are not as well attended as the ones on conditions like diabetes and pre-eclampsia. Is that because they don't affect white women?"

Some midwives saw improvements over recent years in how their trusts were addressing issues for staff and people using services from ethnic minority groups. These included:

- maternity networks to share people's views in the running and development of services, especially when they are representative of the populations being served.
- specific roles, such as cultural safety champions, as long as they are backed up with wider support and resources.

Nevertheless, there was a clear view that there is a huge amount to be done in terms of tackling inequitable care and workforce experience, and this must be based on more open acknowledgement of the root cause. One of the most common phrases used by interviewees was that issues of inequality are 'swept under the carpet'. (Care Quality Commission, October 2023)

Healthwatch Birmingham sought to understand Black African and Black Caribbean women's views of antenatal care, labour and birth, and postnatal care in West Birmingham. They found variability and inequality in the maternity care that Black African and Black Caribbean women receive in West Birmingham. Women experienced inequalities throughout antenatal care, labour and birth, and postnatal care.

These included experiences of discrimination, stereotypes, lack of access to information and interpreters, and not being listened to. The findings also showed that although women experienced challenges at various stages of the maternity pathway, these challenges seem more significant in the postnatal period.

Examples of good practice included:

- Quick referrals to midwife or community care by GPs in the early stages of pregnancy, which aids screening and the support that a woman will receive.
- Consistent antenatal appointments and continuity of care.

- Good communication and adequate information about services and how to access support in between appointments, antenatal classes and complaints process and contact details of key staff.
- Access and quality of antenatal classes - varied ways to access classes (in person or online) and the topics discussed were useful.
- Staff that support women throughout the process, showing compassion and empathy – asking the right questions and acting accordingly.
- Their needs being listened to by staff and support that is person-centred.

Some women talked about the following experiences of things not going well:

- Lack of continuity of carer leading to anxiety and inability to discuss issues such as mental health. This also meant they could not discuss concerns they had and options available to them.
- Failure to be referred to midwives by GPs, which delayed screening and scans. This was particularly difficult for women new to the country and those with a health condition as it delayed monitoring and support.
- Poor staff attitudes and behaviour, more so for hospital staff as compared to community midwives – rudeness, lack of empathy and compassion, poor support for women post labour and birth. Some women felt that their treatment was because they were black. Also of note is that in some cases poor staff attitudes and behaviour came from black staff.
- Lack of access to interpreters or translators meant that those women who need these services are unable to engage during various parts of the maternity journey, especially when giving birth, and their needs are not heard.
- Not feeling they had real choice around where to give birth, and what type of birth to have. Some women felt pressured to have a c-section. They felt that the moment staff see black women, things that are happening to them in the maternity process or procedures are not explained to them. They felt that they are told what to do and not asked, neither do they explain.
- Feeling they were not treated with dignity and respect, with some being asked whether they will have another child soon, use of statements that generalise (e.g. all you people are the same, you guys are difficult).
- Lack of awareness of what support is available, including antenatal classes, even for those having their first baby.
- Feeling ignored and disbelieved about level of pain or being in labour – with some sent back home many times without checking whether they are in active labour. Some women felt that being dismissed had an impact on outcomes, with one woman feeling that the dismissal of her concerns about the impact medicine was having on her pregnancy directly led to miscarriage.
- Experiencing discrimination and racism from those providing maternity care.

- Failure to identify instances needing mental health support and addressing appropriately.
- Poor postnatal support from midwives and healthcare professionals, both in hospital and when at home. Indeed, only one of the women spoke about being invited for a six week check by their GP.
- Poor handling of complaints – failing to take an organisational view when addressing complaints about maternal care and missing opportunities for institutional learning.

Given the challenges in maternity care across most systems in England, it is likely that most if not all of these issues apply to maternity care in Tameside.

(Healthwatch Birmingham, Match 2023)

8.3 Planned Care

Healthwatch England spoke to 1,000 people in a national survey on planned care waiting times. People from ethnic minority backgrounds were more likely to have had their treatment delayed or cancelled than all respondents combined.

People from white British backgrounds were least likely to have had treatment delayed or cancelled and were also more likely to have been given a week or less notice before their care was delayed or cancelled than people from white British backgrounds.

The report recommended:

- Work with patient organisations to improve My Planned Care [My Planned Care NHS](#) and implement the Good Communication with Patients guidance.
- Understand people's experiences better. This might include asking:
 - Why a patient might have rejected a new appointment date following a cancellation.
 - Why they might have turned down the offer for transport to an alternative hospital for care.
 - Why they haven't heard from the patient following recent contact.

(Healthwatch England, June 2022)

The Nuffield Trust reviewed how planned procedure rates varied before and during the pandemic. The analysis of ethnicity showed large ethnic differences in rates of elective procedures before the pandemic:

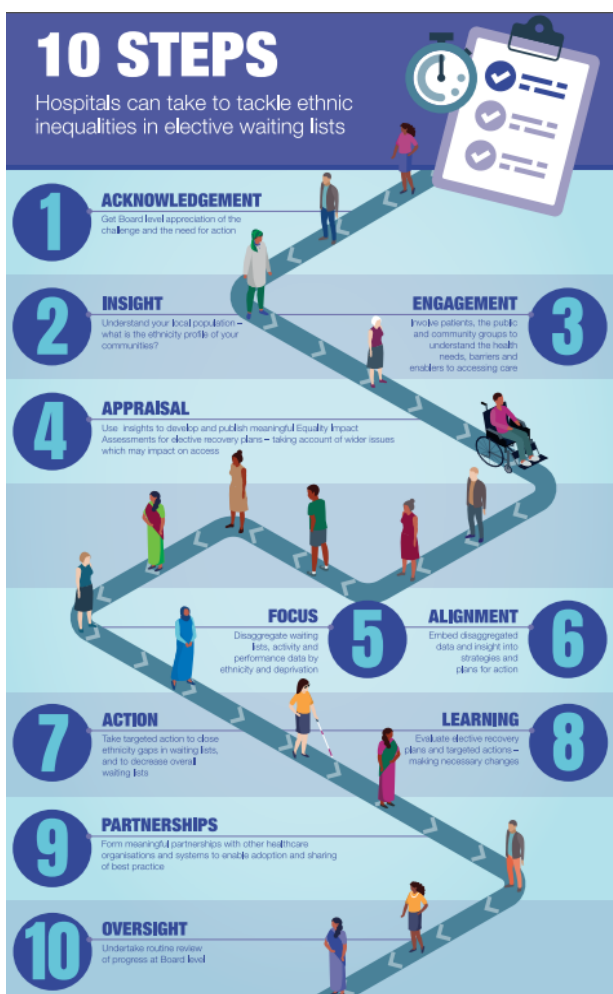
- The Asian group had higher rates of cardiac and cataract procedures than the White group.
- The Black group had higher rates of cataract and dental procedures than the White group.

- However, the Asian and Black groups had lower rates of gastrointestinal and hip and knee procedures than the White group.
- The Mixed ethnic group had consistently low rates of all types of procedure compared with the White group.

Some of these variations are consistent with recognised differences in the health needs of ethnic groups as described earlier in this report.

With a couple of exceptions, the fall in the rate of procedures during the pandemic was consistently larger in the Asian group with larger falls in activity in more deprived areas, confirming that service disruption during the pandemic impacted the most deprived groups the most. Before the pandemic, the most deprived areas had higher rates of elective procedures overall. (Nuffield Trust, 2022)

In response to the findings, the Nuffield Trust and the NHS Race & Health Observatory published 10 Steps Hospitals can take to tackle ethnic inequalities in elective waiting lists:



8.4 Local

When asked about hospital services, Focus Group 1, local women, 5 from the Bangladeshi community and 4 from the Pakistani community, felt that interpreting services are not being used to contact patients, who it is known do not have fluent English.

Referrals are taking too long to lead to hospital appointments – one lady has been waiting 7 months for an ENT appt, which has meant several courses of antibiotics and her family feel she has been far too long on medication, whilst waiting.

People also feel that they have been lost in the system, as there is no communication to them about their long wait. Not everyone feels confident in being pro-active in chasing their referrals up.

One lady made the point that her GP had advised her to go to the walk-in centre at the hospital, only to be told there, after a 3-hour wait, that she should go back to her GP. No treatment or prescription was offered to her.

Another lady had experienced a 12-hour wait at the A & E of Tameside Hospital, with no information and no interpretation available. People reported taking family members to interpret, only to be told that they could not be used for this, despite there being no alternative language support offered.

The group leader also mentioned that she herself had attended a hospital appointment, where she had expected a female doctor to be in attendance and that was not the case. As she had previously asked for this arrangement, the lack of a female doctor was unexpected, and the appointment was made more stressful for her. She could not agree to an examination but agreed to speak to the male doctor only.

When asked about their experiences of hospital services, Focus Group 2, 16 females, including 13 from the Bangladeshi community, one person from the Pakistani community and one person from Spain, raised a number of points:

- Very long waits in A & E
- If you have a letter for an outpatient appointment, the waits are not so bad, maybe fifteen minutes.
- I had a nine-hour wait in A & E, despite being in severe pain.
- My husband had a fall two months ago and our GP made a referral for an X-ray, but we are still waiting.
- My sister is prone to ear infections and was referred for an ENT appointment at Stepping Hill hospital in May but is still waiting.
- One lady reported that she is prone to UTI's and was in pain – the Walk-in Centre passed her on to A & E and the consultant there said she should have

a change of antibiotics. He wrote to her GP but after four weeks, she has still not heard from him, and the medication has still not been changed. She has attempted to get an appointment with the GP, but has now another four-week wait.

- I have a child who has been suffering throat pain and not able to eat properly – my GP made a referral, but I have had to keep pushing for an appointment. I paid for a private consultation which confirmed that treatment was needed but I couldn't afford the cost. It's been four to five months since I first went to my GP with this, and we have still not been seen – it's been passed back and forth from Tameside Hospital to Manchester and back.
- It's stressful to have to wait so long for everything with no explanation – who are they prioritising?

9. Mental health

9.1 National

The NHS Race & Health Observatory review found evidence of clear barriers for many ethnic groups to seeking help for mental health problems, rooted in a distrust of both primary care and mental health care providers, as well as a fear of being discriminated against in healthcare. A lack of appropriate interpreting services also acted as a deterrent to seeking help.

Ethnic minority groups experienced clear inequalities in access to Improving Access to Psychological Therapies (IAPT) and were less likely to refer themselves to IAPT and less likely to be referred by their GPs, compared with White British people.

Ethnic minority people with psychosis were less likely to be referred for cognitive behavioural therapy (CBT), and less likely to attend as many sessions as their White counterparts.

The review highlighted very large and persisting ethnic inequalities in compulsory admission to psychiatric wards, particularly affecting Black groups, but also Mixed Black & White groups and South Asian groups. There was also evidence of harsher treatment for Black groups in inpatients wards, e.g., more likely to be restrained in the prone position or put into seclusion.

Parents reported their children facing the same barriers to accessing services as reported for adult mental health services. Two studies of young Black men showed that they were deterred from seeking help by their knowledge of injustices in mental health services relating to Black Caribbean and Black African populations. Two large national studies found that ethnic minority children were more likely to be referred to CAMHS via social services, education or criminal justice pathways. This was particularly stark for Black children who were 10 times more likely to be referred to CAMHS via social services (rather than through the GP) relative to White British children. (NHS Race & Health Observatory, February 2022)

Pakistani women in the UK are an at-risk group with high levels of mental health problems, but low levels of mental health service use. However, the rates of service use for Pakistani women are unclear, partly because research with South Asian women has been incorrectly generalised to Pakistani women.

Service Disparity: Pakistani women in the UK experience significant disadvantages in accessing and using mental health services compared to white women.

Social Isolation: Pakistani women's social networks tend to be isolating, with high levels of stigma towards mental health issues, which deters them from seeking help.

Stigma and Service Use: The stigma associated with mental health within Pakistani women's social networks influences their patterns of using services.

Need for Specific Research: There is a need for research that separately analyses Pakistani women to accurately assess their mental health service usage and the influence of social networks. (Kapadia, 2015)

Another report looking at ethnic inequalities in mental healthcare in the UK found:

- People from ethnic minority groups in the UK have poorer mental health and access to mental healthcare, and more negative experiences and outcomes compared to the majority white British group.
- These inequalities have been reported for over 50 years.
- Concerns related to experiences of racism, migration, religion, and complex trauma might be more relevant than crude ethnic group classifications.
- In order to develop effective interventions, there needs to be a wide range of perspectives from communities, service users, carers, and mental health professionals in a way that allows interrogation of commonalities and variations in experience across a diverse range of ethnic and lay/professional backgrounds. (Bansal, 2022)

A study on Experience-based codesign (EBCD) conducted in four areas covered by National Health Service (NHS) mental health trusts: Coventry and Warwickshire, Greater Manchester, East London and Sheffield gathered feedback from experts by experience who were over 18 years old, from a minority ethnic group, had used mental health services in the previous 5 years and resided in one of the study areas. Carers and mental health professionals also took part.

Geographical areas were selected to reflect diversity across England including differences in urbanicity/rurality, deprivation and ethnic composition. London was the most ethnically diverse region (57.5% minority ethnic population) followed by Manchester (51.3% minority ethnic population), Coventry (44.7% minority ethnic population) and Sheffield (25.5% minority ethnic population).

Mental health professionals described the importance of codesigning services.

Whilst we're making a little bit of headway with how we support staff; I think with service users we're so far behind and that's because we're not including them in conversations about how we're shaping services.

Service users felt that their views and experiences could help improve access and mental healthcare.

I feel like if people were to understand why we don't reach out for that help, and why we don't feel as though we can reach out, or why it's

such a bad thing, maybe they'd be more understanding on both sides.

Mental health professionals and service users highlighted the need for more diverse staff teams, including in senior positions.

So, I think more Asian staff, having a more multicultural staff. We are all very white from [area name removed.]

We've got a woman Chief Executive at last but before that it was all white male. Still, if you look at all the finance departments, the forensic departments, it's all white.

Mental health professionals, service users and carers described the importance of carefully planned training to provide in-depth knowledge and noted that current NHS training was 'generic' and 'tokenistic.'

I think there are huge gaps in training. I think they're more a tick box exercise—you get the notification on the hub, and you can skip right to the end and fill out your questions without even reading anything. I think if trusts and NHS generally are serious about making changes to accessing healthcare for ethnic minorities, and improving the work environment for BAME colleagues, I don't think that an exercise, a tick box activity really captures the nuances of the experiences these people go through.

Service users described feeling uncomfortable discussing issues pertaining to racism and ethnicity within the mental health setting.

I only felt brave enough to briefly mention it and I know she was apologetic....so I didn't.... It is hard to bring up these things because you get shut down so much when you bring those things up... "Are you sure though..." and the fact that it was so below her consciousness.

Mental health professionals also highlighted barriers to discussing ethnicity and racism within the healthcare setting.

When I've trained and when I've had colleagues, that's been stuff that white health professionals traditionally find really difficult to ask, because people don't want to offend, people don't want to harm.

Mental health professionals, service users and carers described the importance of challenging stereotypes and prejudices and resisting the tendency to 'lump' different ethnicities together.

I think again for me it's really just imploring the experts not to bundle people into groups, so you know, 'this is typical of this group' or 'this is typical of this group'.

.... staff members are still quite far behind in terms of thinking about anti-racist practice. So, there's a lack of accountability in the trust and in terms of the practitioners, how we work.

(Winsper, 2023)

It should be noted that NHS England sets the approach to anti-racism that mental health trusts and mental health providers should take to improve experiences of care for racialised and ethnically and culturally diverse communities. The Patient and Carer Race Equality Framework (PCREF) sets out the legislative and regulatory context for advancing mental health equalities and will assist mental health trusts and other mental health providers to comply with their obligations. It provides practical steps, co-developed with PCREF pilot trusts and early adopter sites, their ethnic led voluntary sector partners, patients, carers and communities, and the regulators to deliver culturally responsive care. (NHS England, November 2023)

9.2 Local

Focus Group 1, local women, 5 from the Bangladeshi community and 4 from the Pakistani community, had no direct experience of using mental health services but they were not thought to be tailored to their cultural needs. The group leader said that there is still a cultural taboo, particularly amongst older generations, about mental illness, including dementia, as it is seen as 'madness' and therefore something to be hidden from society.

Focus Group 2, 16 females, including 13 from the Bangladeshi community, one person from the Pakistani community and one person from Spain had no feedback on mental health services and no-one had mentioned any mental health-related issues in their other comments.

10. Conclusions

This report sought to understand the experiences of people from ethnic communities accessing health and care services. Evidence was gathered from a wide range of national and local reports and articles, along with focus groups held in Tameside.

It highlights that it is well known that certain health conditions affect ethnic groups more than white groups, such as diabetes and cardiovascular disease, and that ethnic communities often live in areas of high deprivation, with social determinants such as housing, environment, education and income compounding poor health. Inactivity and social isolation also contributes to poor health. Access to the right services is even harder if you have both a disability or long-term condition and you are from an ethnic community.

There are significant challenges with current data. Ethnic categories are not sufficiently nuanced and granular, combining many different cultures into broad categories. There are also challenges with the quality of data captured using those categories. In some areas, little data exists. There is a recommendation for this to be explored further.

Reduced access to GPs is exacerbated for people from ethnic communities as they may have more challenges using online or telephone access.

Information is not routinely provided in their first language, and some services do not follow the Accessible Information Standard and ethnic communities have difficulty accessing quality interpreting services for medical appointments.

There is a distrust of mental health services, evidence shows a disproportionate number of people from ethnic communities are held in secure mental health wards and people from ethnic communities are less likely to be referred for preventative services such as Improving Access to Psychological Therapies (IAPT).

Maternity services are frequently highlighted nationally as not meeting the needs of women from ethnic communities and being discriminatory. Although we haven't found data on this topic in Tameside, we feel this should be explored in more detail in Tameside.

11. Recommendations

Healthwatch Tameside recommend the following based on the information contained within this rep:

- The findings in this report informs that granular data for ethnic categories within health care is limited and where there is data there are issues around quality. Therefore, Healthwatch Tameside recommend that further work is undertaken to review how ethnic data in health care is captured and utilised within Tameside.
- The report highlights through patient experiences that access to primary care can be difficult. These experiences also suggest there is variation in the use and offering of interpretation services for patients. Therefore, Healthwatch Tameside recommend that interpretation service are made available and offered to patients if required or requested at first point of contact.
- The report informs that there is lack of information in non-English languages and on digital tools available for patients. Therefore, Healthwatch Tameside recommend patient information is available in a range of languages to support accessibility and to develop a readers panel for reviewing such material to ensure information is culturally appropriate.

12. References

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