Derby Health Inequalities Partnership Community Consultation: 2021/22

KEY FINDINGS

Acknowledgments

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Contents

Background

The Derby Health Inequalities Partnership (DHIP) is a co-led, joint initiative between Derby City Council Public Health and Community Action Derby, working together with community organisations and leaders to help achieve better health outcomes in the city. The DHIP was started in response to the COVID-19 pandemic which shone a light on inequalities in the city and highlighted the good work and potential of communities to respond to this scale of challenge. Its further development was recommended by the COVID-19 Local Resilience Forum Health and Welfare Cell which identified a gap for Derby City in community led health planning. It is also a practical response to the increased interest in community engagement as a response to health inequalities as recommended in national reports such as the Public Health England disparities report (*Disparities in the risk and outcomes of COVID-19: Public Health England, 2020*), see Appendix 1 for further details.

Initial DHIP meetings identified a need for community consultation and engagement to understand what health issues are most important within our communities, with the aim of capturing the human experience behind the inequalities data in Derby. Following a successful pilot in November 2021 the community engagement programme (CEP) began in December 2021 and ran until May 2022. The CEP was led by a Working Group, which involved representatives from Derby City Council and Community Action Derby.

Methods

Data Collection

Fifteen community researchers were trained to undertake the community consultation, which took place from January 2022. The consultation involved over 150 people, from a variety of local groups and communities, including primary schools, Hadhari, Sahahra, Active Through Football, CAD Community Services team and the Youth Alliance. Those involved reflected many of Derby City's Black, Asian, Minority Ethnic and Refugee communities, although there were some notable gaps, including Chinese, White: Polish, Latvian, Czech and European settlers.

The eight questions used in the consultation were co-designed with members of the DHIP and final versions were as follows:

1. When am I feeling at my best?
2. Please tell me about health issues you see in the community and your family?
3. Why do you think it is like this?
4. What stops you or your family getting the help you need?
5. What would you like there to be more of to support you or your family's health?
6. What can we do to stop the unfair differences in health?
7. What has been your experience with health services in Derby?
8. What can be done better by health services to support people like me?

Data collection methods varied depending on the needs of the group consulted and included the following:

- Community group meetings
- Collecting notes on flipcharts using the questions as headings
- Creation of video content
- Informal one-to-one and small group discussions

The facilitators shared anonymised notes and feedback from these exercises with members of the CEP Working Group. The CEP Working Group held a meeting to collate all the feedback into one anonymised transcript which was then analysed by the Derby City Council Public Health Intelligence team. The report was then reviewed by the facilitators and a Support Officer from the Public Health team to ensure that the report accurately reflected the data collected.

Data Analysis

The transcripts were analysed using Braun and Clarke's thematic analysis. The process of analysis primarily involved an inductive approach to coding, allowing the data to determine the patterns and themes identified. Deductive coding was then employed, using pre-defined codes from the findings of the initial CEP pilot. Once saturation was reached, codes with similar themes were grouped together and organised into sub-themes. From these sub-themes, overarching themes were identified from the data.

Once the themes had been independently analysed and grouped they were then reviewed by the community researchers and further developed to ensure they reflected discussions. More sub-themes were added and extra quotes were selected to further illustrate the themes. This process of participant validation was important to ensure the findings reflected the original discussions and were owned by those involved.

The key findings were written up into this report and a short film also produced to reflect the conversations and the deep sense that things need to change – see Appendix 2.

Data Limitations

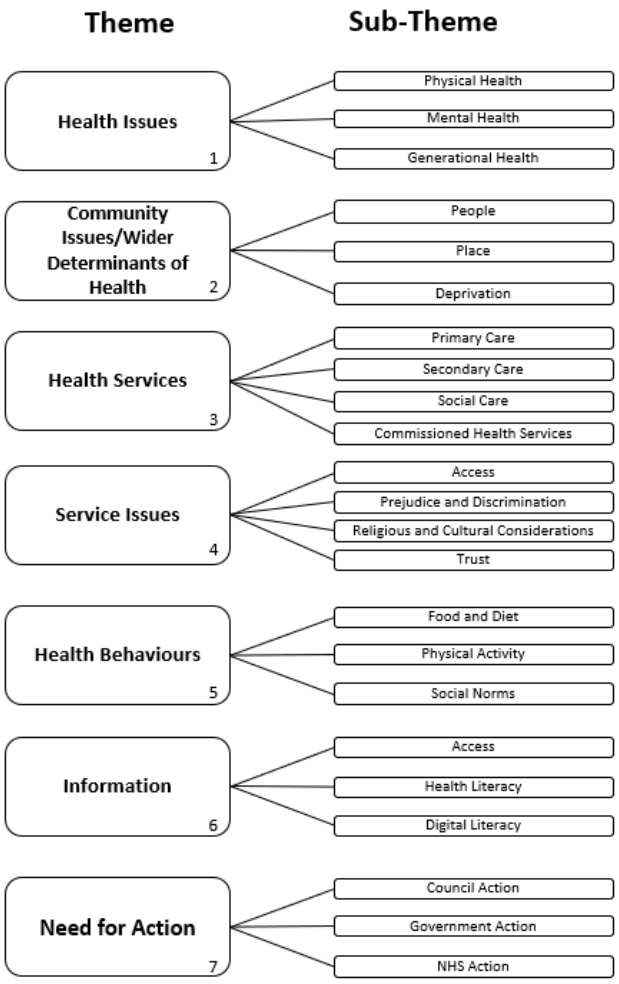
The consultation data and findings should be used and interpreted with the following limitations in mind:

- As written text, the report does not adequately reflect the emotion and strength of feeling that was generated during many of the focus group discussions. As only a selection of quotes are used to illustrate the themes, the issues could be perceived as diluted and have less impact.
- The method used (community-based participatory research) to gather information is a pragmatic and evidence-based approach and relied on accessing data from community groups where trust was already established. There may be gaps with groups or communities where relationships are underdeveloped or do not yet exist.
- Consultation implementation was significantly affected by the Covid-19 Omicron wave in Autumn/Winter 2021.
- Limited capacity across partners at the time of the consultation impacted on the depth and reach of the consultation, as well as the timeliness of the analysis.
- Some consultation participants were unwilling to be recorded which meant that facilitators had to rely on note-taking at the time. Some valuable information may have been missed.
- Secondary compilation of notes was used for analysis purposes. This protected anonymity but may have missed some useful detail and may create inaccuracies due to interpretation bias.

- Engagement and involvement with the consultation may have been limited due to consultation fatigue and feelings that it has 'been done before'.

Key Findings

Seven overarching themes were identified from the thematic analysis: health issues, community, health services, health behaviours, information, service issues and the need for action. From these seven overarching themes, a number of sub-themes were also identified.



Theme 1: Health Issues

Community consultation participants discussed health issues from several perspectives. Of particular concern was physical health, mental health and generational health.

Physical Health

Participants shared many concerns surrounding the general poor physical health in Black, Asian and Minority Ethnic communities and the normalisation of some diseases along with concern of the taboos related with sexual health.

- *'Within the Pakistani community there is a known Vitamin D deficiency. This appears to be related to increasing levels of dementia. Other health conditions, especially diabetes are also prevalent'*
- *'Dr's saying diabetes is common in your community (south Asian). It shouldn't be and they should be doing something to change that. They have just labelled the community with it.'*
- *'In some cultures, it is seen as desirable/good to be 'overweight', seen as strong'*
- *'Sexual health: very taboo subject across the board.'*

Mental Health

The difficulties surrounding the taboo subject of mental health was also discussed. This has been impacting the support they are receiving, including from their own communities as they do not feel able to discuss it within their own families. They also conveyed that because of this, it was exceptionally difficult to discuss with professionals, especially in such short appointments.

- *'Mental growth is ''stunted'. Importance of mental growth is not widely known, things like family day trips and experiences aren't valued and understood. It impacts mental health too.'*
- *'No mental health support for BAME males suffering from poor mental health and nothing is done about it, still taboo, people are still laughing and stigmatising it in and out of these communities.'*
- *'GP's don't understand the issues and complications of life when it comes to BAME communities' and mental health, nor can we explain it to them properly, as there is no time and they don't listen'*

Generational Health

Participants felt that a cycle of ill health was being perpetuated inter-generationally, however, they believe that some members of the younger generation feel willing to change this if given support.

- *'Young people are frustrated that they have been left in this situation, generations of ill health and wider determinants have negatively impacted them.'*
- *'Some young people are understanding these issues and are willing to change, others are stuck in these generational cycles.'*

Older generations are also perceived as having different influences on their health, compared to younger generations who look up to their elders.

- *'Older (Muslim) generations are influenced by people like Imams, not the youth so much.'*
- *'Older generations would work off the food with hard labour, work is different nowadays, so the same foods are eaten but not 'burned off.'*
- *'We look up to our grandparents, our grandparents are not active and never have been – but they've made it to 60/70 years and are ok.'*

Theme 2: Community Issues/Wider Determinants of Health

Participants discussed their communities in-depth and within this, sub-themes of people, place and deprivation emerged.

People

Discourse on people focused on the advantages of networks for healthcare access, but also the use of this for the exclusion of others in the community, by community members who may look down on those who are less privileged.

- *'Social Circles this group has means they may know Drs or health care professionals to ask questions or advice and can utilise their own networks.'*
- *'Closed network that don't want to mix with underprivileged, even though they are from same communities, they act as community leaders or representatives when they do not have the connections/respects/links on the ground.'*

Participants discussed the busy lifestyles of people in their community, which can be a barrier to staying fit and healthy. They also discussed there being a lack of support and outlets available especially for young people or those who may be carers.

- *'People in the area are not interested in health and fitness, they are busy surviving, raising kids, caring for family members, paying bills and now there is covid on top of everything else.'*
- *'It's not a lack of interest or willingness in people, there's just no outlets. The opportunities are no longer there.'*
- *'Support for young people or carers is not there, its massively impact on their education, burden on their shoulders, should not be adding to this, rather asking how they are and how they can help them.'*

Place

Discourse on place was predominantly negative and focused on a lack of safe and green spaces in their communities, the wide availability of takeaway restaurants in Normanton, in addition to the location of sexual health services as a hinderance to service use.

- *'Taxi stand outside [sexual health clinic], so Asian families wouldn't go there because they feared who they will see/someone will see them.'*
- *'There isn't indoor or outdoor space that's safe for us to socialise or be active, like football. Indoor spaces cost too, but if I play outside and trip and ruin my clothes I get in trouble at home.'*
- *'Drug dealing in Arboretum has got worse. It's very evident now. It's a shame because it's a nice park'*
- *'Lack of opportunity visit green space – don't do much outside of school and visiting Mosque'*
- *'Lack of safe spaces – just because there are 2 parks here doesn't mean the job is done. Its unsafe to go out alone, especially for women, potential to be a racial abuse target if out in traditional clothes.'*
- *'Why were so many takeaways licenced in Normanton and why wasn't the impact on health a concern? New takeaways are still springing up.'*

Deprivation

It was discussed throughout that long-term deprivation within Black, Asian and Minority Ethnic communities has a massive impact on health and underpins the ability to improve health or allow for social mobility. Poor housing and overcrowding have a large impact on people's starts to life and can cause a number of health issues. Participants felt that this was particularly perpetuated in Normanton. There was a sense that this issue is an inevitable cycle.

- *'I was one of 7 children in a 2-bed house with my family. It was difficult'*
- *'Poverty, deprivation, overcrowding in housing is so common.'*
- *'Refugees are pumped into areas like Normanton with no plan and support, to keep the area from growing and improving'*
- *'BAME communities are used to living in poverty and deprivation, it's scary and challenging to think of anything else as this is the reality and comfortable. They have adapted as best they can in hard times and worried it could be worse, often overshadows the possibility of progression.'*
- *'Social mobility and deprivation- Though financially some communities are better off, quality of life is not there.'*
- *'System and government is designed to keep BAME communities living like this (in Normanton) for their benefit and the economy (prisons, low income jobs).'*

Theme 3: Health Services

Participants discussed health services, encompassing primary care, secondary care, social care and commissioned health services.

Primary Care

Discussion predominantly focused on primary care and their thoughts were typically negative, expressing frustration with long waiting times, feeling rushed during appointments and the impact of COVID on seeing a doctor face-to-face. They also felt that GP receptionists negatively impacted their experiences.

- *'People with existing conditions pushed back, people have died in the pandemic because they couldn't see their GP so cancers weren't diagnosed.'*
- *'Mis diagnosis is common, which leads to Over prescribing of meds with no follow up. Tablets are thrown at you. Then you get to the hospital, and they say to throw them all out and that you don't need them. What effect have these medications had on us up to that point? Why is there no accountability for the mistake from DRS/ GPs?'*
- *'Can't get through on phone and when you go to surgery, and they say go home and get back on phone. Having to wait in a telephone queue is time consuming and costly.'*
- *'Using covid as an excuse to not see us, government and the rest of the world changing advice, but they are happy to sit at home and just call us. Some things a Dr needs to actually see and not hear about. Talking to GP face to face also allows people to open up and maybe talk about the REAL reason they have come in.'*
- *Receptionists accusing patients of lying, exaggerating symptoms to get appointment. They are not Drs and do not have the training, how can they be qualified to triage patients over the phone and speak rudely. They seem to be bored of their jobs, do they not understand most people are not at the Drs for happy or good reason, there is no human or customer service and consideration.*
- *'Dr's from the same communities look down on underprivileged and blame them for their health status or conditions. Non BAME/White Dr's treat us better.'*
- *'GPs no longer examine patients thoroughly. They have a few minutes to ask you a few questions and it is like they can't be bothered and don't care.'*

Although, there were positive comments on repeat prescriptions services and the use of online services in facilitating their ease of seeing a GP.

- *'Access to online services, make it quick and easy to see GP'*
- *'Some areas have a good repeat prescriptions service.'*

Participants felt that the business aspect of healthcare was taking over, with less of a focus on customer care. Along with feeling that when they do make complaints, they are ignored and covered up.

- *'NHS business side of things takes over customer care element.'*
- *'They look after each other, complaints don't go anywhere, as they protect their own, they don't investigate it properly, they place the blame on the patients'*

Secondary Care

People who are receiving secondary care for diagnosed conditions expressed a lot of concern. It was highlighted that people were being pushed to go private in order to receive secondary care which is not accessible or affordable for a lot of Black, Asian and Minority Ethnic families. Participants also raised several concerns about social prescribing, A&E treatment of Black, Asian and Minority Ethnic patients along with maternal care, focusing on the black community.

- '*GP's in deprived areas are saying if you need treatment or access that urgently than go private. How is this appropriate or even possible'*
- *'A&E seems to treat BAME/colour differently across the board'*
- *'Waiting times are long in A&E and other hospital appointments/ referrals.'*
- '*Social prescribing: not enough culturally specific services that Dr's refer to'*
- *'Black maternal health and deaths, lack of pre and post-natal care, child and death in infancy, miscarriages, SIDS, traumatic birth, insensitive care on wards (evidence in PHE disparities report and Black Lives Matter manifesto). Why are these things still an issue and a concern'*

Social Care

Social care assessments were highlighted as being insensitive to the increased cultural hospitality of Black, Asian and Minority Ethnic families and therefore not accurately assessing the need of individuals meaning they are missing out on vital support.

- *'Negative feedback, being tested in PIP assessments-'make me a cup of tea' then are told they are mobile enough to do so, so are not eligible. Hospitality of communities is taken advantage of here, people will go out of their way to welcome guests into home.'*
- *'Some people get everything and others get nothing, they know or don't know how to work the (social care) system.'*

Commissioned Health Services

Participants discussed negative experiences with health services that are commissioned by local government and the NHS. It was raised that these are not culturally appropriate or accessible for Black, Asian and Minority Ethnic communities and therefore do not support their needs.

- *'Tried to get help from a lifestyle service but was offered Eurocentric advice and offers of fitness that did not meet my needs.'*

- *'I do not want to go to a gym in a predominantly white area with white instructors. My English is not good enough" There were no Urdu or Punjabi speakers.'*
- *'The council should put funding into the area to set up local fitness activities and even venues – who goes to Derby Arena or David Lloyd from this area??'*
- *'I had a heart attack and afterwards was sent to some exercise classes. I had to go out of the area as there was nothing in the community.'*
- *'(in reference to commissioned services) Employ more Pakistani fitness staff (especially since Covid has hit our community and highlighted the dangers of being overweight and unfit)'*

There was specific emphasis placed on Drug and alcohol provision in the city for Black, Asian and Minority Ethnic communities. It was raised that the Christian 12-step program is not appropriate for a large proportion of Black, Asian and Minority Ethnic service users. They also felt that alcoholism and addiction is not something that is addressed or recognised as it is taboo within their communities and services could be doing more to support this.

- *'12 step programme is based on Christian ethos, doesn't apply to other BAME communities'*
- *'Alcoholism is a big issue, particularly in South Asian communities, that no one is addressing or recognising'*
- *'Addiction in communities, its taboo, they need to know it's common and happened and there is support, signposting of information.'*

Theme 4: Service Issues

Participants discussed a variety of issues with health services. The issues can be arranged into four sub-themes: prejudice and discrimination, religious and cultural considerations, access, and trust.

Prejudice and discrimination

Participants reported numerous experiences of prejudice and discrimination in relation to their access to health services. Racial stereotypes and further prejudices have been reported, including negative assumptions about individuals' financial situations when using a service. Participants were concerned that members of their community are being treated differently when using a service due to their accent or their appearance and have been mistreated because of this. The lack of competency with phlebotomy of Black, Asian and Minority Ethnic patients was also raised multiple times.

- *'Double standards between different communities, from front line staff, from the way they communicate and the way they are treated. Ethnicity takes over, Asian man from India must have 'TB', preconceived ideas and diagnosis, leading to mis treatment.'*
- *'Stereotyping of conditions, not believing patients 'it's all in confidence' was said when assuming liver pain is related to alcohol abuse in an Asian man who has told them that due to religious beliefs, they do not drink alcohol.'*
- *'I speak English but because I am not smartly dressed and am Asian, I still get treated like I am dumb and my comments fall on deaf ears.'*
- *'Mixed race girl with white mother calls GP with no issues, however dad with accent has very different experience 'abrupt, dumbing down info' over the phone/ in person. Clear prejudice and judgment.'*

- *'Blood tests on darker skin: can't find the vein, take too long, try too many times, need experiences staff, dread around those nervous of needles,' have they been trained?' they feel very unexperienced'*
- *'Assume we are all on benefits or want benefits, and that's why we are there.'*

Religious and cultural considerations

Religious and cultural considerations were commonly featured. Participants felt that Doctors and nurses lack an understanding of cultural issues, common health problems and family dynamics among Black, Asian and Minority Ethnic communities. Poor interpretation services also impact the ability of patients to convey their thoughts and feelings and overall, this hinders the quality of conversations with healthcare professionals and affects their health outcomes.

- *Wards are cutting hair of elderly Sikh men, because they cannot 'look after' his hair.'*
- *'No empathy, no cultural understanding and importance of family care and dynamics when it comes to health and treatment/ wellbeing.'*
- *'Females having to talk about personal or intimate issues with male doctors so things get missed or forgotten, and that is dangerous.'*
- *'No regard to religion, family told that 'hospital is not a mosque' when asked about prayer facility.'*
- *'HCPs are not aware of health challenges that are common/prevalent in other communities and countries, and that affects treatment, doctors don't know how to deal with these issues, there are simple treatments that they are not aware of i.e., some skin conditions that are common in some African communities.'*
- *'Poor interpretation service, interpreters who do not relate or portray the issues, they mis interpret, which affects outcome and treatment of patients and disease.'*

There are also concerns that doctors push services which are not culturally appropriate and there is a lack of culturally specific services, particularly for food/diet plans for diseases such as diabetes which is focussed around a western diet and therefore not applicable or helpful in treatment.

- *'Doctors push services/ support that are not culturally specific, including social prescribing'*
- *'Culturally specific information is not available i.e., carbs and chapattis, and how it negatively impacts disease and weight management. Teaching eldering Asian people with type 2 Diabetes how to make a healthy jacket potato is not helpful as they do not eat that food.'*

Participants feel that there is a lack of consideration for religion or culture in health services and patients have been prescribed medicine or been given food containing ingredients which are not appropriate for consumption.

- *'No cultural/ religious consideration: not respecting religions i.e., forcing inpatients to eat food they cannot have i.e. pork and ingredients in meds i.e. gelatine, patients are not even made aware.'*

Additionally, participants felt that they could not trust their GP or the NHS. The long-term impact of colonialism has affected the way communities feel about and engage with authority. Young people are more likely to consult the internet for health information because of this, others feel the need to take an advocate to their appointments to ensure the GP understands their health concerns.

- *'Can't trust GP some feel the need to take an advocate, to double check and support them in the appointment, to make sure the GP is actually listening, understands the issue and is doing the right thing for me.'*
- *'NHS not accepting or apologising for past mistakes, adding to mistrust'*
- *'Young people don't trust GP surgeries, will usually go online for health information.'*
- *'Anti-state sentiment in YP: any institution, as they feel left to live in deprivation and poverty and blamed for things, things like prevent agenda/government policies targets Muslim youths, feel there is a hidden agenda therefore sceptical of things like NHS, over thinking the motives of those that are 'helping. Need to be mindful of this and build those relationships and trust to support them.'*
- *'Colonialism has had a big impact on how communities react and engage with authority including: NHS, government, police. Agencies need to be very mindful of this.'*

Access to health care

Finally, participants expressed their frustration with accessing health services. Common concerns related to long waiting times and being unable to get through to their surgery on the phone which can also be unaffordable and will inevitably have a negative effect on their health.

- *'Can't get through on phone and when you go to surgery, and they say go home and get back on phone. Having to wait in a telephone queue is time consuming and costly.'*
- *'Can't even get a sick note from Dr now, how is that fair. I had to pay for one for proof through a private firm.'*
- *'A strong sense of GPs still using Covid as an excuse to not see patients. All appointments always taken and phones constantly busy.'*
- *'A and E has appalling waiting times. Waited 15 hours.'*
- *'Can't get NHS dentist, can't get appointment.'*

Theme 5: Health Behaviours

Participants discussed health behaviours, focusing on food and diet, physical activity and social norms.

Food and Diet

Participants were concerned about the rising cost of food, particularly with fruit and vegetables being expensive compared to the cost of a takeaway increasing the challenge of eating healthily.

- *'Food prices – fresh fruit and veg too expensive, takeaways cheaper and lots of them - why so many in Normanton?'*

Participants also discussed the poorer quality of food in more deprived areas and although cheap isn't always better, many people do not have a choice.

- *'Food is not as good quality or openly available, therefore the health benefits are taken out of it (i.e., plantain, cassava), less shelf life of food.'*
- *'Deprived areas get exploited by businesses, quality is sacrificed i.e., end of date foods, cheap isn't better, however you don't have the choice.'*

Physical Activity

Participants also discussed the fact that physical activity is not prioritised in many households, particularly when people have a busy lifestyle where people are balancing working long hours, looking after children, completing housework and fitting in prayer.

- *'Physical activity isn't prioritized in some communities or households, sitting on the PlayStation means parents can get on with the things they need to do.'*
- *'I don't need to be active, it would take a lot for me to be; housework is exercise, if I had the time to exercise I would rather spend it relaxing as I am so busy. By the time you have sorted the children, done the housework and your prayers, the day is over, there isn't time for anything else.'*
- *'I'm a taxi driver so I'm sitting most of the day, I don't have the option of exercising during a shift. I need to be paid.'*

Exercising outside of the home was considered to be embarrassing in the Pakistani community and shameful for women, which prevents them from partaking in such activities.

- *'Doing exercise outside of the home is embarrassing, people take pictures and videos and laugh at you, if a Pakistani woman was seen jogging in the street, it would bring shame on the family.'*

Social Norms

Participants discussed how social norms interact with the health behaviours in their communities. They believe ill health and low life expectancy have become normalised, seen as reality, and therefore there is a lack of understanding of the possibility of changing this.

- *'Diabetes is normal in some communities, and it shouldn't be.'*
- *'Expectation of ill health in 'old age' need to challenge that mentality, we have to understand we can live healthy life expectancy.'*
- *'Early death is normal, low life expectancy is expected (grandparents passing at 60 is seen in some communities as a long life)'*

Theme 6: Information

Participants discussed information in relation to having access to information on health services and health behaviours. Additionally, they discussed information as important for improving health literacy and digital literacy.

Access

Participants felt concerned about their access to information on living a healthy lifestyle and services available, including mental health support. Many of the participants voiced that they felt unsure of where and how they could access help because of this.

- *'Where do we send the mentally ill? No one wants to know about them.'*
- *'GPs don't have time for MH issues, people don't know where to go and the traditional family support structures are badly fragmented and in some cases gone completely.'*
- *'Depression/ suicide: Where to access information, and how.'*
- *'Not enough information, advice guidance in community regarding health and health behaviours.'*

Information is not available in suitable locations – for example, it is currently not helpful for information to be located in GP surgeries, as patients are often not attending appointments in-person. Information is also not reaching younger people in the right spaces, leading to a disconnect between them and services available.

- *'Comms and information: it's not out there, its unseen, no one's going GP surgeries, so can't see the posters, there's no connect or visibility.'*
- *'People or coaches don't relate to us, we don't know what's going on, what's available, maybe if they came into schools or reached out on Instagram and Facebook we would know.'*
- *'Self-referral schemes are complicated, and no one knows what is available or how to access.'*
- *'There's no connect between NHS services and comms and youth.'*

Health Literacy

Concern was also expressed regarding health literacy, influenced by a lack of access to information to make informed decisions about their health. People reported a lack of understanding of the need for services such as screening, widening health inequalities.

- *'Inequality gaps are increasing because inner city and deprived areas have poor access to health services. Screening uptake is lower and people don't understand the need for screening, health checks etc.'*

Additionally, there are difficulties understanding doctors' explanations due to the terminology used, further impeding the ability to make informed decisions about their health. Resources are also not readily provided in alternative languages, despite the diversity of these communities. This has further caused a lack in trust as patients have signed medical paperwork when they do not understand what they are signing for treatments.

- *'Terminology that Drs use, not explaining things in layman terms, they make it confusing and scary'*
- *'Used to trial medication of us, they don't explain anything and then expect to get a nod or signature. Most people have to go along with it, and the if something goes wrong, they chuck the signed paper back in your face, saying you knew the risks.'*
- *'Don't explain or provide any information written in different languages readily.'*

Digital Literacy

A move towards digitalising aspects of services, such as booking systems and appointment reminders excludes populations who lack digital literacy and access to the internet. This is especially impactful on the older generations.

- *'Online booking systems excluded elders and especially BAME elders. E.g. Walk in centre phlebotomy or London Road phlebotomy services required online booking and then use of a computer to book in and medical staff on site refuse to help so BAME elders have had to ask fellow patients to log on for them, giving personal details to complete strangers.'*
- *'Elderly person missed a series of appointments as details were sent by text and he can't read.'*
- *'Everything is moving online, and they just expect everyone to have access to smart phones and internet'*

- *'Pushed to go on to the internet for advice. There are issues with language, literacy levels and access'*
- *'Phlebotomy: need to log in on computers, not everyone can read or write or use these systems…GP's threatening diabetic patient who cannot book via system to strike them off the surgery'*

Theme 7: Need for Action

Participants expressed a desire for change and for the council, the government and the NHS to take action.

Council

From a council perspective, participants discussed the continuation of the licensing of multiple takeaways and fast-food outlets, in addition to betting shops. They also feel let down by council inaction on a number of further issues including pest control and pollution from traffic fumes.

- *'The Council don't do anything nor do the police and it is a nightmare for those with respiratory problems (traffic pollution).'*
- *'Rats are seen running round the area and invade homes, the Council don't help and no one is tackling this.'*
- *'Fast food and takeaways: Why is council licensing so many of these shops in these areas? People will buy it if available.'*
- *'Deprived areas have more betting shops, expensive corner shops.'*

Government

In relation to the government, participants questioned why more isn't being invested into health services. They also discussed the colonialism of countries from which many Black, Asian and Minority Ethnic people originate and the mistrust this has caused in the government, along with recent wars supported by our government which have caused many Black, Asian and Minority Ethnic refugees to move to England in recent years.

- *'Why don't they invest more? Health services are always on a budget yet there is always money for foreign aid and things that don't concern us. "Sick of being asked by doctors and nurses: do you know how much this will cost? Have been paying taxes since I was a young man and am now long retired but they see me and mine as freeloaders.'*
- *'Colonialism has had a big impact on how communities react and engage with authority including: NHS, government, police. Agencies need to be very mindful of this.'*
- *'A lot of Muslim people that have arrived more recently have fled war torn backgrounds because of western intervention. Britain is associated with this, which doesn't help build trust with services provided by 'government.'*

NHS

From an NHS perspective, participants feel unheard and want to discuss their experiences face-to-face. They believe the NHS needs to build trust among young people and to communicate with Black, Asian and Minority Ethnic community groups. There was a specific focus on the ability of staff

to insert cannulas on Black, Asian and Minority Ethnic patients and the need for recognition of past initiatives which broke trust such as drug trials on Black, Asian and Minority Ethnic groups.

- *'HCPs cannot put in cannulas on darker skins, where is their training?'*
- *'NHS need to adopt a different mindset, lack of lived experience led initiatives, live a day in the life of these communities'*
- *'First experience is so important, too many negative experiences i.e., trials and vaccinations on Roma'*
- *'Used to trial drugs on us'*
- *'We need the NHS to hold face to face discussions with us and to listen to our complaints and our stories, often horror stories of how the NHS have treated us, now they are pushing us to go private.'*
- *'NHS policies are not geared towards communities/individuals, but to system and targets.'*

Overall, participants felt that systematic change from the top is required to address deprivation, but also top-down initiatives were common, and communities need to be more involved for these to ensure they are successful and accessible.

- *'Need community-based approaches in both hospital and GPs'*
- *'Bridge the divide: those from ivory towers come to communities, not community representatives but hear what we have to say straight from 'the horse's mouth'*
- *'Messages and information needs to come from a partnership, not just young mother or kids, it needs to come from multiple agencies so we can get the message across to as many people as possible.'*
- *All initiatives have been top led, dictating to the community what has to be done. At the start people were interested, but once they realised no one was really listening and they didn't have any real input they backed off. It doesn't matter how much money you chuck at it. There are never really going to take off without community input and support.*
- *'Systematic change from the top Is needed to challenge deprivation.'*

Recommendations

Feedback from the community consultation phase has highlighted the need to address a variety of issues and provides an outline of the scope for this.

1. Bridge the knowledge gap between healthcare professionals and communities, ensuring that information is widely accessible and that individuals can make informed decisions about their health. Part of this should involve the provision of translated resources and improved interpretation services.

2. Healthcare professionals are to be trained to be culturally sensitive. Improvements should be made to the provision of culturally specific services, including those focused on drugs, alcohol, sexual health and preventive behaviours such as diet and physical activity.

3. Healthcare professionals to be given further training on the use of medical tools on darker skin including phlebotomy and the use of pulse oximeters.

4. Support Black, Asian and Minority Ethnic families to talk openly about health issues including addiction, sexual and mental health.

5. Religious and cultural considerations to underpin all care, health promotion and information provided to individuals and communities.

6. Increase number of community events which aim to tackle loneliness and mental health.

7. Community-based and co-produced health promotion and information events are required to address social norms and engage communities in culturally sensitive discussions regarding health behaviours. Consider hosting events in faith centres/places of worship.

8. Continued engagement with communities to improve understanding of the gaps in services currently provided.

9. Health services commissioned locally by the government and NHS – such as Livewell, Phoenix Futures and sexual health services should measure and report on how effective they are at meeting the needs of Black, Asian and Minority ethnic communities.

10. Acknowledgement of variation in digital literacy among populations and where it is not possible to avoid digital use, support to be provided.

11. Transition away from top-down initiatives which do not consider the opinions and experiences of the communities being engaged with, instead NHS and Local Authority to build in the role of community participation.

12. The NHS should pro-actively and continuously work to build relationships with communities, particularly among the younger generations, providing support and gain their trust.

13. A health in all policies approach should be prioritised across Derby City Council for the purpose of building and sustaining an environment which promotes healthy behaviours.

14. Further piece of work to be conducted into questions 5 and 6 ‘What would you like there to be more of to support you or your family’s health?’ and ‘What can we do to stop the unfair differences in health?’ as it was apparent that communities were not yet equipped to answer these questions.

15. Specific actions should be agreed and prioritised as soon as possible to support the dissemination of this report across the system.

Appendix 1: Disparities in the risk and outcomes of COVID-19

In June 2020, research was conducted by Public Health England reviewing the risk and outcomes of COVID-19 on existing disparities. The report looked at a number of characteristics including age, sex, geography, deprivation, ethnicity, occupation and whether they were a resident in a care home. It then evaluated their experiences over the COVID-19 pandemic and confirmed that COVID-19 replicated or heightened the impact of existing health inequalities.

The most relevant findings from the report were:

Those living in the most deprived areas had higher diagnosis, and more than double the death rates, of those living in less deprived areas.

Death rates from COVID-19 were the highest amongst Black and Asian ethnic groups.

Occupational disparities showed those working in social care; nursing, midwifery, and nursing associates; men who were security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, and construction and processing plant workers were significantly more likely to die following infection.

During the COVID-19 pandemic, people who were born in Central and Western Africa, the Caribbean, South East Asia, the Middle East and South and Eastern Africa evidenced a large increase in all deaths compared to those born in the UK and Ireland.

Comorbidities were widely linked with poor outcomes, with diabetes mentioned on 21% of COVID-19 death certificates; Black, Asian and Minority ethnic patients with diabetes had a much higher chance of death compared to White ethnic groups with similar disparities evidenced in those with hypertensive disease.

Data further suggested that the prevalence of COVID-19 was significantly higher in those with no fixed abode than in the general population.

Disparities in the risk and outcomes of COVID-19: Public Health England, 2020

Appendix 2: Voices Film

“In early 2022 the DHIP held a number of conversations with members of Derby’s Black and Asian communities.

This short film reflects their experience of health inequality, in their own words.

This film gives a voice to those who shared their frustrations, aspirations, and the deep sense that things need to change.”

Voices

https://mailchi.mp/8998330ac6cf/dhip