NHS
Sheffield
Clinical Commissioning Group

Written evidence from NHS Sheffield Clinical Commisioning Group (CCG)

1. Summary

- Racial inequalities are widespread in the UK and in Sheffield and this causes health inequalities and affects BAME people's health and health outcomes.
- BAME people have higher rates of some conditions ie diabetes, heart disease and mental health conditions and higher rates of some cancers, and are more likely to be diagnosed later affecting survival.
- Money allocated to sheffield fo GP servicses doesn't reflect the needs of deprived communities, cementing health inequalities.
- The make-up of our workforce doesn't reflect the ethnic make-up of the population, although our governing body broadly reflects ethnicity of the city.
- There's some good practice in healthcare to reduce inequalities by extra funding for certain practices, interpretation and new models of care to improve access.
- We believe the best ways to tackle racial inequalies are: engage better with communicties, disproportioaly invest to people with greatest health needs, shift funding from hospitals to the community and integrate services.

2. Introduction

NHS Sheffield CCG is a membership organisation made up of 75 GP practices. The CCG uses the clinical expertise of local doctors and nurses, supported by experienced managers and lay members, to commission (plan, monitor, and fund) health services.

On behalf of Sheffield people, we use our annual budget of circa £900 million to commission the majority of local health services the public need and use, such as those from hospitals and community services.

3. Evidence of racial inequality in Sheffield

Below is a summary of local and national evidence of racial inequalities in the city.

3.1. Population

Around 19% of Sheffield population are from a BAME background, yet they're overrepresented in many health conditions groups and underrepresented in health service use, more likely to be unemployed, live in deprived areas (38% of BAME population live in 10% most deprived areas in Sheffield which is above the citywide average of 23%) and have poorer educational attainment. Moreover, Bangladeshi, Pakistani, Chinese, and Black groups are about twice as likely to be living on a low income and experiencing child poverty as other groups.

3.1.1. Engagement findings

Over the last few years, the CCG carried out lots of engagement with BAME communities. Here is a summary, which may indicate racial inequalities.

- BAME respondents (16%) were most likely to have said they would visit A&E if a long term condition worsened, compared to 8% overall population.
- Navigation of the system and services is more challenging for those with little knowledge and confidence in how it works, and this is compounded by factors such as speaking English as a second language.

Experiences and views around Covid

- Increase in calls regarding suicidal thoughts from BAME men, particularly Bangladeshi, Yemeni, and Somalian.

- During the pandemic, there has been a palpable sense of loss in BAME communities. This is due to bereavement but also a sense of inequality on the back of Black Lives Matter, Grenfell, Windrush, and Brexit. The pandemic has compounded those feelings.
- There's a lack of access to culturally appropriate support and not accessing mental health services, including a reported increase in attempted suicides
- There is strong feeling that BAME organisations have been under-resourced in Sheffield, or short-term funding hasn't helped develop to thrive. BAME organisations feel that anchor organisations and VAS have extensive infrastructure costs and therefore when they collaborate, they receive very little funding to deliver work on the ground.

Asylum seekers and refugees

- Failed asylum seekers who live with long term conditions are particularly difficult to support, as they are often 'sofa surfing' and therefore cannot carry large quantities of medication drugs for fear of physical assault / may not have access to places to store them appropriately (e.g. insulin in a fridge).
- People arrive needing health care following time in a refugee camp where there's little access to medical facilities, doctors or nurses. People are often unable to read English and therefore understanding prescriptions, instructions for medication usage, letters for specialist clinics etc. is entirely reliant on project workers.
- People want culturally appropriate services; understanding and reflecting people's communities. Stigma, trust, language, and cultural barriers can prevent people from BAME communities from accessing statutory and mainstream services.

Primary care interpretation services:

- The face to face Interpreting service commissioned by the CCG (provided by Language Line Solutions), is generally viewed as working well by users.
- The telephone interpreting service is not always popular and impedes effective communication between patients and clinical staff due to the fear of a confidentiality breach.
- Users have told us occasions where the interpreter had not understood basic clinical terminology and had relayed inaccurate information, including the word "brain" instead of "heart" during a meeting between patient and consultant before heart surgery. Another example involved inaccurate and potentially very harmful instructions being relayed to a patient before a colonoscopy.
- Issues with timeliness of interpretations, appointments and quality of language spoken.

3.1.2. Health profiles

Nationally and locally, there's the evidence from PHE and health profiles.

Physical health

- The Somali community has one of the highest A&E admission rates, higher rates of COPD and diabetes.
- BAME pregnant women are x8 more likely to be admitted to hospital with covid19 symptoms.

Diabetes

- Diabetes is higher amongst Indian men and women, Bangladeshi men and women, black Caribbean men and women, and black African men.
- The prevalence of diabetes is much higher for Pakistani women, aged 55+ , than it is for men in that age group.

Cardiovascular disease

- Indian women aged 55+ have a higher risk of ischemic heart disease (IHD) or stroke, with the prevalence increasing with age.
- The highest prevalence of IHD or stroke occurred amongst Pakistani men (41%)

Cancers

- Prostate cancer makes up over 40% of Black men's cancer compared with around 15% among Chinese men and 25% among all men
- Black women were more likely to be diagnosed with breast cancer at a late stage compared with white women.
- Black ethnic group were more likely to be diagnosed with colorectal and lung cancer at late stage compared with other ethnic groups.
- For prostate cancer, white, Asian or Chinese ethnic group having the highest proportions of late stage diagnosis.

Lifestyle
- Black African women had the highest obesity prevalence (38.5%) of any BME group, 20 percentage points higher than Black African males.
- Black men were reported to have the highest rates of drug use and drug dependency than other groups.
- 40% of Bangladeshi men in England are current smokers, compared with 24% of all males.
- Levels of physical activity are lower among South Asian groups than other ethnic groups, with South Asian women having particularly high levels of inactivity
- The National Child Measurement Programme indicates that among children most minority ethnic groups have higher levels of overweight or obesity at age 10-11 than the white majority. Those in black groups have the highest levels.

Life expectancy
- Studies have found the gap in life expectancy between traveling community and settled community to be as high as 20 years. They have higher rates of long-term illness, arthritis, asthma, chest pain, chronic coughs, bronchitis, and diabetes mobility problems.
- For Roma, life expectancy is estimated to be around 10 years less than the European average. Roma child mortality rates are 2 to 6 times higher than those for the general population
- Sheffield's infant mortality rate is higher than the national average (3.9 per 1,000 live births). The inequalities gap between the most and least deprived areas is widening. Infant mortality rates are highest among Pakistani, Black Caribbean, and Black African groups.

Mental health
- Available data suggest lower levels of reported 'wellbeing' among most minority ethnic groups than the white population.
- Deterioration rates following psychological therapies are greater in non-white ethnicities compared to white ethnicities. Recovery rates following psychological therapies are higher among white ethnicities compared to all other ethnicities.
- People in lower income households are more likely to have unmet mental health treatment requests compared with high income households. And BAME people are more likely to live in lower income household.

Asian people
- Research indicates that older South Asian women seem to be an at-risk group for suicide.
- One 2018 review found that non-European immigrant women, including young South Asian women, were a high-risk group for suicide attempts.
- There is a stigma around mental health in the UK Chinese community. Mental illness poses greater difficulties for those who have language barriers, cultural differences, and differing concepts of mental illness.

Black people
- Black men have higher reported rates of psychotic disorder than men in other ethnic groups
- Risk of psychosis in Black Caribbean groups is estimated to be nearly seven times higher than in the white population.
- In England during 2017/18, amongst the five broad ethnic groups, rates of detention for the Black or Black British Group were over four times those of the white group.

- Suicide rates are higher among young men of Black African, Black Caribbean origin, and among middle aged Black African, Black Caribbean and South Asian women than among their white British counterparts.
- A 2009 study of Somali refugees found around 1 in 3 suffered from long-term illnesses, including mental health conditions. Many are living with the aftereffects of war and the refugee experience.
- Refugees are more likely to experience mental health problems than the general population, including higher rates of depression, PTSD and other anxiety disorders due to pre-migration experiences and post-migration conditions (such as separation from family, difficulties with asylum procedures and poor housing)
- The concept of depression is not understood in the Somali language.

3.2. CCG staff

We know nationally in the NHS ethnic minority staff are more likely to be discriminated against, more likely to experience bullying, harassment and abuse, and less than to be in senior positions than white staff.

At Sheffield CCG:

- We employ 345 staff, just 8% of whom are BAME
- The Governing Body has 17**%** of BAME members
- 0% of BAME staff are in manager positions (agenda for change band 8 and above).
- BAME staff were less likely to have experienced bullying or harassment than white colleagues.
- BAME staff more likely to disagree that the CCG acts fairly about career progression or promotion.

4. Your organisation's analysis of the cause or causes of racism or racial inequality in Sheffield

The CCG believes the causes of racial inequalities and racism are multi-factorial and complex. Systematic racism, which has developed over decades, if not centuries in the UK, has undoubtedly led to grave inequalities.

Our analysis here is focused on racial inequalities, particularly which lead to health inequalities or inequalities in NHS workplace.

Race inequality is one factor of wider inequalities. The wider social determinants of health such as the unequal distribution of housing, employment, wealth, healthcare, and education lead to health inequalities. There's a wealth of evidence that shows health outcomes are correlated to income or wealth - economic inequality leads to health inequality.

This leaves many BAME people in poor health, living with unhealthy behaviours or social practices, such as smoking, drug use, poor diet, and insufficient exercise, and with lower life expectancies. BAME people are disproportionally affected compared to white groups.

These are the societal or governmental causes of health inequalities, but ethnocentrism and unconscious bias in the health system can and does compounds these effects.

Moreover, the national NHS budget allocation doesn't go far enough to cover the needs of deprived populations. Particularly, the GP allocation (known as the Carr-Hill Formula) doesn't reflect the complex needs of patients, this cements inequalities and hardwires it further. Practices are rooted in communities and fundamental in helping patients not just with their health but other needs such as universal credit, social care and interpretation of official letters.

5. Examples of good practice in relation to reducing racism or racial inequality (from Sheffield)

5.1. Population

Significantly Added Patient Pressures (SAPP)
Needs of GP practices with high BAME populations is not reflected in the national Carr-Hill funding formula, so the CCG gives extra funding to practices that have a high number of patients needing interpreters.

This lack of national funding, additional demands this group of patients presents and the additional work practices was highlighted by practices.

This funding is split across 7 of the most affected practices and is based on weighted list size and has a total spend of £300,000 a year. Practices use the money to employ practice staff who speak community languages, additional clinical hours to run longer clinics helping to give BAME communities the time and level of support needed for effective consultations.

Mulberry GP practice
We commission the Mulberry GP practice to provide health care to vulnerable populations including asylum seekers, refugees in the process of settling in the UK or victims of human trafficking.

The patients have complex physical and health needs, and often don't speak English. On top of the usual GP services, here are extra services for these patients including use of interpreters; additional time to work with patients; and enhanced screening and vaccination programmes.

The staff are experienced in working with people with mental health problems and in distress. They work closely with the City of Sanctuary, Refugee Council, and infectious diseases team at the hospital.

Interpretation services
To help with equality of access, we fund telephone and interpretation for all GPs in Sheffield via a contract with Language Line. These practices can book ad-hoc interpreters at no cost to them.

We're piloting a scheme in the city that plays messages within practice waiting rooms in several languages. In Page Hall Medical Centre where the majority of patients are BAME, important health messages are played in different languages such as Urdu, and Romanian.

Death certificates provided at weekends
In Muslim culture, a burial with 24 hours of passing away is important. Longer waits can cause distress to families and friends.

It can be difficult to do this if a patient dies over the weekend, as GPs aren't able to provide death certificates. To prevent delays, practices ensure a GP is on call over weekends for Muslim patients who are receiving palliative care and expected to die within days.

New models mental health care
In Sheffield, there's a gap in mental health services for who have a higher level of need than IAPT (psychological therapies) but do not meet community team thresholds. Over the last 12 months, up to 4,000 patients in Sheffield are believed to have fallen into this category. Sheffield is one of twelve areas piloting new mental health support in the community.

New services are currently being tested in 4 areas of Sheffield. In 3 months, seen over 400 patients and significantly improved access to BAME communities. Under previous services BAME communities accounted for 11.6% of all referrals, this figure has increased to 21% (within the Foundry area selected for its inequalities and higher BAME population, this access rate increases to 39%).

5.2. Staff
Black Lives Matter (BLM) fikas

Fikas are an opportunity for staff to meet for conversation. They are based on Swedish tradition where over a coffee and pastry, Swedes chat with their colleagues.

Following the BLM protests in the summer, CCG staff organised two virtual fikas with a BLM theme. The fikas were well attended by staff from across the CCG, including the governing body.

An open and honest conversation about racism can be difficult to have. The fikas provided a safe space for staff to share and consider their own experiences of racism. Feedback indicated that staff were engaged with the issues and keen to engage further.

At the end of the second Fika staff were invited to make pledges. These included to change individual behaviour and/or to learn more, and commitments from Governing Body members to influence change.

Internal equality group
Staff have set up an equality, diversity and inclusion group which exists to promote equality, diversity and inclusion within the CCG. The group is currently looking at issues related to recruitment, how the CCG presents itself (for example on social media) and ways to increase awareness within the staff body.

Reverse mentoring
Staff within the CCG were encouraged to attend a Governing Body drop in session on Thursday 9th January 2020. A member of staff from a BAME background took this opportunity to introduce themself to GB members but also to raise some concerns they had experienced throughout their employment. Below is a summary of challenges outlined:

1. Support of governing body members to help support and promote key religious and recognisable events within the work place.
2. What is currently being done as a commissioning organisation to help address the stigma of mental health In BME communities and accessibility of services for these groups?
3. An unfair representation of the current workforce, a challenge made to Governing Body members to review this.

Lesley Smith (Accountable Officer) felt it would be a great opportunity to undertake a reverse mentoring pilot which could be implemented throughout the organisation.

Prior to COVID-19 a couple of sessions had been completed and there was an action plan for unconscious training to be resourced. Although COVID-19 has impacted the sessions, the staff member has stated that they believe the reverse mentoring has brought more awareness to staff such as Black Lives Matter Fikas and the newly established Promoting Equality and Diversity group within the CCG which the Deputy Accountable officer attends.

6. What your organisation believes to be the best way to tackle racism or racial inequality in the city.
Although the solutions for tackling racial inequalities are so much wider than the NHS, the CCG has a fundamental role in tackling them as a health commissioner and employer. We can only make a difference to deep rooted problems, by working with partners across Sheffield. We are signed up to ACP's BAME strategic priorities plan, and our deputy accountable officer is executive lead in Sheffield on delivering the plan.

There's no magic bullet, but from a health perspective, we believe the following are the best ways to tackle racial inequalities:

- Disproportionally invest in services and community assets which are targeted at those with greatest health needs, with a focus on BAME communities. This is a shift as an organisation from focusing on equality to equity. Here people would be given unequal but proportionate levels of support and funding based on needs to improve their health.

- Shift NHS funding and staff from hospitals to primary and community care at population level, including grassroots organisations. Currently, we are constrained by national NHS England and Improvement performance and contractual frameworks.
- Better integration of NHS, council and voluntary sector services. It will help people with long-term conditions and people with complex lifestyles.
- Acknowledge racial inequalities as sub-set of wider health inequalities and target our interventions. Without this, solutions will be ineffective in reducing racial inequalities.
- Continue to engage with BAME people and community groups to hear their concerns, views, and ideas and use this intelligence to shape our commissioning plans, empower grassroots community groups, and then co-create new services and pathways with them. To do this invest and support community capacity building.
- Improve ethnicity data collection, analysis and reporting on access, health condition prevalence, patient and staff experiences.
- Improve interpretation services in primary care.
- Improve the health literacy of BAME people by working in partnership with community organisations.