Report to the Race Equality Commission

27th November 2020

Dr Caroline Mitchell MD FRCGP DRCOG

GP and Senior Clinical Lecturer University of Sheffield

Academic Link to the Deep End Cluster Research Network (DE Sheffield CRN)

On behalf and including feedback from Shameen Khan DE CRN Manager , Elizabeth Walton DE CRN GP Clinical lead, DE CRN reports and GPs working in the 'Deep End Sheffield CRN and at the 'Asylum Health' practice , Sheffield Health and Social Care Trust in Sheffield

The Deep End Sheffield Cluster Research Network (DE CRN)

The DE Sheffield CRN was inspired by the Glasgow Deep End project. This 'Deep End' group working with the University of Glasgow has undertaken over a decade of research which has demonstrated the impact of inequalities on the mortality and morbidity of the population alongside health inclusion implementation projects with practices and practitioners (workforce, clinical interventions, continuity of care, link workers, pioneering training schemes). The Glasgow Deep End project comprises 100 practices serving the most deprived populations- in Scotland. This is now a growing UK wide and Global movement.[i]

DE Sheffield CRN was founded in 2016/2017. The cluster comprises nine practices in Sheffield, covering 63,865 patients. The 'index of multiple deprivation (IMD) is > 40 for all the practice areas covered which is the most deprived end of the most deprived decile of IMD in the UK. The cluster is supported by a small annual grant from the NIHR (National Institute for health services research grant) to support development of practice research capacity and to undertake high quality , peer reviewed and nationally funded research studies with full ethical and research governance approvals. Six of the practices have BAMER representation significantly higher than the UK population.

Practice population characteristics by NHS coded ethnicity

1. 15.6% 3.6% mixed,3.7% asian,6.6% black,1.7% non-white other
2. 13.4% 3.6% mixed, 3.5% asian, 4.6% black, 1.7 non-white other
3. **61.1%** 4.2% mixed, 37.9 asian, 9.7% black, 9.3% non-white other
4. **48.9%** 4.9% mixed, 18.8% asian, 15.9% black, 9.3% non-white other
5. **53.1%** 4.6% mixed, 24% asian, 14.3% black, 10.2% non-white other
6. **36.5%** 4.1% mixed, 17.6% asian, 7.7% black, 7.1% other non-white other
7. 14.9% 3.2% mixed, 4.9% asian, 4.8% black, 2% non-white other
8. **39.5%** 3.2% mixed, 18.1% asian, 10.6% black, 7.6% non-white other
9. **49.3%** 5% mixed, 26.9% asian, 9.6% black, 7.8% non-white other

The CRN has an integrated 'Patient, Practitioner and Management group' which is a unique resource for researchers to present their work from grant submission through to patient recruitment. . High levels of research engagement in the practices, large stakeholder events in Sheffield 2019 to celebrate the three years of DE CRN, a local Migrant health and research conference (2018) , presentation of DE Sheffield work by Dr Liz Walton in Glasgow at an international event in April 2019.

This report is compiled with first hand feedback from practitioners at the 'frontline of care.

Key challenges for inclusion health and inclusion research:

In summary:

- Lack of co-production of solutions with practitioners and the communities
- Continuing racism partly fuelled by local print and social media which fuels challenges faced by the practices in providing care and the negative experiences of ill health and NHS care reported by patients
- Language barriers to inclusive healthcare- lack of a systematic and sufficiently resourced support to provide timely, culturally appropriate language support and healthcare trained interpreters. Practices that have tried to innovate eg with dual trained receptionists recruited from the local community do not get the necessary sustained additional funding needing for the additional time needed for patient support. Patients prefer trained interpreters face to face and / or support from family and community to 'language-line' services.
- Lack of training in working with interpreters in secondary care and some third sector services
- Practices have the same resources to look after people with significant health and language challenges as patients without these challenges and there are disproportionately more of such patients in these practices. This mismatch of resource and health need is widely described (Marmot report, Glasgow Deep End research etc)
- Practitioners and a diverse group of patients are keen to participate in research. However, a lack of necessary additional resources to support inclusive research (especially health literacy and language needs) is a major barrier to participation in studies.

1. **Evidence of racial inequality in Sheffield**

- **Practitioner 1 providing primary NHS care for asylum seekers**

'*During Covid whilst the actual rules for lockdown were translated into different languages (mostly by charitable organisations such as Doctors of the World), there is a woeful lack of translated wellbeing materials. So whilst I could direct English speaking patients to lots of different websites on wellbeing there was very, very little I could direct my non-English speakers to.*

Many of the mental health services (including a number of third sector organisations aimed at supporting mental wellbeing) either do not use interpreters or can only offer interpreters for a limited range of languages. It feels like many services simply throw their hands up in the air and declare "too difficult" "we can't do it" which saves the service from the problem but does not help the individual seeking support.

In physical care the secondary care service providers are not all trained in the importance of using professional interpreters, or in how to do so. I have lost count of the number of times I have received out-patient letters saying " the consultation was difficult as there was no interpreter present" or "We used her friend as an interpreter". Or (slightly better) "The appointment will be

rebooked as no interpreter was present" which at least recognises the importance of an interpreter but does inconvenience the patient – why was no interpreter booked? And why was a telephone interpreting service not available?

- **Practitioner 2 DE CRN**

'Many residents from the BAME community live within the more deprived wards in Sheffield where there is poor housing and overcrowding. I am not sure about whether the council invests disproportionately in these areas – there is certainly a lot for them to do!
People living within deprived wards tend to develop chronic ill health significantly earlier than in wealthier wards, and tend to have lower life expectancy.

Attempts to communicate crucial public health messages do not appear to be adapted to meet the needs of communities who are illiterate or cannot read English – thus further marginalising an already disadvantaged community.

Resources to provide core primary care services do not include any consistent or permanent financial contribution to accommodate for the specific needs and demands of a migrant BAME community.

Community health education resources & classes often exclude non-English speakers, despite their high need for support with certain health conditions eg diabetes (DESMOND- a group lifestyle intervention), obesity (LIVE LIGHTER), heart disease (Community Cardiac Rehabilitation), anxiety and depression (NHS IAPT- Increasing Access to Psychological Services).'

2. **Your organisations or your own analysis of the cause of racism or race inequality in Sheffield**

- **Practitioner 1 providing primary NHS care for asylum seekers:**

'*Groups are labelled as "hard to reach" but I think the truth is they are "easy to ignore". My patients will not sue the health services and will not make a big noise about how badly they are treated by services. They are too busy, too worn down, too disempowered, too frightened of causing waves and do not know how to work their way around the system or how to stand their ground when they are told that is all that is available. By denying people regular, consistent access to state supported English classes we manage to deny them a voice.*

Inadequate funding to services that have to use a lot if interpreters (to take into account the additional time every interpreted consultation takes up) means that services for non-English speakers are invariably at a disadvantage compared to those for English speakers – the inverse care law applies again and again. Walking down the back alleyway to the Mulberry Practice in Sheffield, which serves asylum seekers and victims of traffickers really illustrates the esteem with which this group are held. The entrance is down a back alley where rubbish is put out of back doors and spills on to the street. Inside many of the consulting rooms have no opening window or windows that look out on brick walls a few feet away. The environment sends powerful messages.

Income inequalities multiply the barriers. When a bus fare is a significant proportion of your daily income (possibly a return ticket = your daily income given that asylum seekers live on just over £5 per day) even getting to the services you need may be too expensive.'

- ***Practitioner 2 DE CRN***

'It is hard to measure and fund 'bespoke' health services 'fairly' so it not funded at all' Political unwillingness to fund services for migrants, when all budgets are tight'.

Cost of housing and restrictions on housing opportunities. Racist attitudes at some levels – 'they should learn to speak English' . Lack of understanding of the challenges some communities face. Those of us working within these communities are often not consulted about the problems we see every day. Short-term investment in small projects, which raise expectations and are often successful, but then disappear

- ***Practitioner 4 DE CRN***

'From my perspective of working in an area where many people are born outside the UK at the moment language barriers are key .. Here is one covid related thought ...

The current model of a shift to total telephone triage is further disadvantaging access to health care for those who have limited English proficiency. In my experience needing an interpreter is not an either/ or thing. There is a cohort of patients who can normally manage with a simpler appointment system and face to face consultations without need for an interpreter. Life has got more difficult for them and us, as clinicians, moving to the telephone. So working like this doesn't feel " more efficient" as i think it might in an area of more affluent digitally literate English speaking patients. It feels really tiring and slow and with a large cognitive load. A simple problem can take 25 minutes with a three way telephone appointment to solve which in the past could have been managed safely in 10 minutes by " eye balling" a patient. I am concerned going forward into post pandemic times that the push for remote access to GPs will further widen inequalities to healthcare.'

3. **Examples of good practice in relation to reducing racism or racial inequality (from Sheffield, elsewhere in the UK or overseas)**

- **Practitioner 2 DE CRN:**

IAPT Sheffield are developing bespoke translated group sessions in Urdu & Arabic (women-only) in 'improving wellbeing'. This has taken a lot of time and effort, campaigning bby local groups and practitioners.
MAST parenting classes in other languages .Darnall Wellbeing ran an excellent project to develop Roma Health Trainers but this ended due to unsustained funding

SHSC trust ran an Emotional Wellbeing Worker project (Urdu and Arabic speaking wellbeing workers who offered transformational interventions) – but the funding ended and the service was lost. SOAR (Social Prescribing hub) / Firvale Community Hub ran a weight loss class for the Roma community

Musculoskeletal services request specific info about language needs in order to support patients to book their appointments

Individual organisations (health, education, VCF) working hard to support their local communities eg employing bilingual reception staff, making Youtube videos in several local languages, continuing to raise the profile of disadvantaged and over-looked communities

Availability of ESOL classes within the local community. Funded interpreter services for parts of the system to facilitate crucial communication between the person and the professional

Elsewhere: enhanced services (in primary care) to draw funding in to specific communities (http://www.sussexccgs.nhs.uk/wp-content/uploads/2020/06/BAME-Vulnerable-LCS-FINAL.pdf)

- **Exemplars from the DE CRN:**

July 2019: Migrant Health. This was a vibrant and overbooked event. We heard from local GPs who run the Asylum Seeker health service, TB nurses, Refugee Council workers, British Red Cross workers, an Infectious Diseases Consultant, Academics including medical students who were are supporting in their projects researching barriers to screening and also patient preference with regard to interpreters; we also heard the Director of Public Health in Sheffield, Greg Fell. This was a joint event funded by Sheffield CCG Health Inequalities Steering Group to re-launch a 'New Arrivals' group in Sheffield to promote health of new migrant patients using an intersectional approach. We hope this bustling meeting overfilled with patients, psychologists, health trainers, physiotherapists, doctors nurses and academics continues to thrive under the leadership of Darnall Health and wellbeing organisation.

We are currently actively supporting recruitment for the COVID vaccine and virus watch studies and supporting local and regional strategy groups to support inclusive research.

Examples of relevant research undertaken by 'Deep End CRN linked researchers and the group:

Adapting primary care for new migrants: A formative assessment. Br J Gen Practice Open January 2017. BJGP-2016-0620. Top Ten BJGP Open papers 2017. DOI: https://doi.org/10.3399/bjgpopen17X100701.

Interpreter costs across clinical commissioning groups in England 2017–2018: a cross sectional survey using 'freedom of information' requests. British Journal of General Practice. 2020 Jun 1;70(suppl 1).. https://doi.org/10.3399/bjgp20X711377

Professional Resilience in GPs working in Areas of Socio-Economic Deprivation: A Qualitative Study. Br J Gen Pract Dec 2018; 68 (677):e819-e825. doi.org/10.3399/bjgp18X699401.

Exploring patient preference regarding interpreter use in primary care-a qualitative study. British Journal of General Practice. 2020 Jun 1;70(suppl 1). https://doi.org/10.3399/bjgp20X711557

What influences Roma women attending NHS cervical screening? Knowledge, fear, and passive consent- a qualitative study. British Journal of General Practice. 2020 Jun 1;70(suppl 1). https://doi.org/10.3399/bjgp20X711089

4. **What you or your organisation believe to be the best way to tackle racism or racial inequality in the city**

- **Practitioner 2 DE CRN**

'*Champion migrant residents and communities*
Positive stories in the local press

Fund sustainable programmes to grow and develop volunteers from local communities who become paid community champions in specific areas eg health, education, welfare, social & council issues.

Employ communication experts

Develop community focus groups to test out new messages / ideas / services and co-develop resources which will be acceptable and engaging for the communities they are targeting.

Fund core services to accommodate the demands and needs of local migrant communities eg health, education & welfare services'

- **Practitioner 3 DECRN**

'Champion and support student and professional training placements and posts within core services (health, education and welfare) in BAME areas to both attract and 'grow their own' high calibre staff

Offer innovative training opportunities within these organisations to develop a more diverse workforce and leadership (e.g HCA and nurse apprenticeships, Physician Associate preceptors)'

- **Practitioner 4 DE CRN**

" A key thing would be increasing access for women born outside the UK to be have safe women only local venues in which to learn and gain confidence with English and for more links to be built between the third sector delivering such language provision and local GP surgeries. We are ideally placed to signpost patients to local groups and classes but are often not good at doing this just from lack of time to find out what's out there and needing some easy to follow information to hand to patients " (student R did some work on this for Burngreave)

- **Feedback from Cluster research meetings and the Clinical Lead of the DE CRN Dr Walton**

An annual report is produced each year summarising our work and shared with all the practices, our PPI group and shared widely eg public health, Sheffield City Council.

The most common feedback given by the Deep End Cluster professionals and patients to researchers who attend our meetings is to challenge why interpreting costs are not included in grant applications … ''at some of our practices up to 70% of our consultations are with interpreters; we believe there is an 'inverse participation law' in relation to the exclusion of patients whose first language is not English in research''

We are keen to build on recruitment and have plans to contact practices in a more strategic and organized way and support engagement of more people in excellent clinical research We know that organisations that participate in research activity provide overall better care and there are better patient clinical outcomes. .There are challenges to recruitment at the Deep End: workload, lack of grant money for interpreters, patients with complex psychosocial

problems which can lead to an 'inverse participation law', administrative errors. However, we are committed to the importance of research for our patients going forwards.

[i] https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/