Tackling Health Inequalities in Rochdale

Seminar Report

Monday 13 June 2022

Maqsood Ahmad and Fatima Khan

Introduction

Tackling health inequalities in Rochdale is a partnership project between Rochdale Council and the British Muslim Heritage Centre supported by Rochdale community organisations. The main focus of the project is on the Kashmiri, Pakistani and Bangladeshi (KPB) communities.

The main reason we are focusing these communities initially because various research and our experience s of working with these communities show that they have a higher prevalence (in comparison non-South Asian Communities) of several risk factors that can increase the likelihood of health inequalities.

These risks can lead to developing diabetes 2, cardiovascular disease, stroke to contributing towards the individual's mental health. Risk factors, such as family history, gender, ethnicity, and age cannot be changed. However, other risk factors, such as high cholesterol, high blood pressure, smoking, diabetes, obesity, physical inactivity, and poor nutrition. In addition, we are aware that that Covid-19 has a disproportionate impact on the South Asian Community (including KBP communities).

Our thanks to all those attended and contributed towards the roundtable discussions and to all our speakers to set the scene on how we can work together to tackle health inequalities I Rochdale in partnership with the KPB communities and groups.

The aims of the seminar

1. To bring together individuals and groups to explore the best way to tackle health inequalities within their communities
2. Explore the possibility of establishing a tackling health inequalities network.

Maqsood Ahmad

Maqsood Ahmad, Chief Executive of the British Muslim Heritage Centre. welcomed everyone one for attending and went through the aims of the seminar. He also highlighted the health inequalities facing the KPB communities including long term conditions such as cardiovascular diseases, diabetes, dementia and mental health to deprivation in many of the areas that they lived and worked in Rochdale. He thanked Cllr Daalat Ali, Gemma Dillon and Dianne Gardner for their commitment to this project and looked forward to working with them and the community groups.

Maqsood outlined the seminar programme (appendix 1) to the participants and stated that the seminar is designed to be interactive ensuring that the participants voice is herd as well as knowledge based presentations by guest speakers.

Cllr Daalat Ali

Cllr Daalat Ali, Deputy Leader and Portfolio Holder for Health welcomed everyone to the seminar and outlined the Rochdale Council's commitment to tackling health inequalities. He stated that in order to tackle this serious issues is one of the priorities of the Council and his colleagues. He was pleased that so many people attended the seminar to give their time out to engage with the council officers. He briefly outlined the health structure within the Council and his responsibilities as portfolio holder for the health.

Cllr Ali emphasised on the importance of obtaining the correct and meaningful data at a local level in relation to tackling health inequalities so that the support and involvement could be organised to help those who need it most.

Table Discussions

Two roundtable discussions were designed to prompt collaborative dialogue and understanding between the community members. These discussions responded to two key questions (i) what is your understanding and experience of health inequalities and what influences them? (ii) how can we tackle health inequalities on an individual and community level? In each case, one person was chosen by each table to feedback to the large group discussion. As the discussions progressed, facilitators and community members identified important patterns and emerging themes.

Themes identified from roundtable discussion 1: what *is your understanding and experience of health inequalities and factors that influence them?*

1. **Lack of timely and culturally appropriate communication**

According to this group of community members, there is a lack of timely and culturally appropriate communication which they experience at multiple levels, including, for example:

a) **Interpersonal level:** the most frequently cited communication difficulties were interpersonal, between individual community members and healthcare providers and these oscillated around language barriers that resulted in significantly decreased access to all health services. This was especially worrisome for those who speak lesser-known South Asian languages.

b) **Community level: c**ommunity members cited a lack of consultation before significant local changes in primary and secondary health care services and systems are implemented. To illustrate this, community members referred to the closure of Rochdale Infirmary multiple times and lack of agility and responsiveness when booking GP appointments. Further, they indicated the lack of knowledge sharing and engagement with the community would prevent long-term negative health outcomes.

"GP appointments are difficult to get over the phone and it takes such a long time!"

"We need to be able to book advance appointments with GPs"

c) **Signposting and direction:** where services do exist, there is a lack of awareness in the community. Community members identified a need to both seek active participation of communities, offer education, and raise awareness around existing healthcare services and systems.

d) **Lack of communication between services:** community members cited a lack of 'joined-up' care, whereby updated patient information is not effectively shared amongst healthcare services leading to miscommunications, time-wasting and heightening frustrations, fears, and anxieties in already fraught contexts.

"Services are good, but you have to fight or be pushy"

"Staff must be given time by management to follow-up and update their records"

2. Lack of accessibility:

While language barriers decrease access to health care, issues of accessibility to health care are much broader. The lack of access to GP surgery appointments despite persistent attempts and time spent on the telephone was identified major barrier to timely care and a source of frustration. Discussions also identified a lack of inadequate awareness of disability needs within health services and public buildings. A lack of easily accessible information about palliative care and care parking costs makes accessing hospitals prohibitive.

3. Erosion of trust due to lack cultural and religious sensitivity:

In addition to a decrease in accessibility due to language barriers, community members identified an overarching lack of cultural and religious sensitivity that amounts to a tacit form of exclusion. Community members cited being treated condescendingly or as a source of annoyance by primary healthcare professionals (GPs and dentist were specifically cited):

"My doctor is unwilling to listen to me and always fobs me off"

"GP's think we are undeserving of their time and service - almost as though we are some lowly citizens unworthy of their attention"

"Inferiority complexes towards ethnic languages need to be dismissed"

This, along with the issues of lack of communication and accessibility described above is leading to the ongoing erosion of trust between local Muslim communities and healthcare providers. This will lead to further exclusion, which in turn will exacerbate existing health inequalities.

Themes identified from roundtable discussion two: *how can we tackle health inequalities on an individual and community level?*

1. **Meaningful community engagement:** Community members continually identified community engagement and consultation as the building block for tackling health inequalities on multiple reasons, including, for example:

- To design and deliver effective services, affected communities must be engaged at the grassroots level from inception to implementation. Services that are 'helicoptered in' without consultation run the risk of replicating factors that exacerbate exclusion and are unlikely to be successful in the long-term.

- To implement much needed community based and targeted prevention work.

"We have a terrible situation in the community where so many people have developed chronic diseases which could have been prevented if appropriate support had been provided at the right time."

"Review patients with underlying conditions more regularly so those conditions do not become worse"

- To raise awareness of health care services that are already available in the local area but are not well known. To raise awareness of UK healthcare rights for refugee background people.

2. Raising cultural and religious awareness amongst healthcare professionals: An issue raised across all small group discussions, community members identified the need for service providers to understand diverse cultural issues and to provide culturally and religiously sensitive care where required. Educating health care professionals in the arena of cultural, linguistic, and religious sensitivities transcends their immediate practical purposes in the healthcare setting. For community members the presence or absence of such knowledge in the health care encounter is indicative of the extent to which Kashmiri, Pakistani and Bangladeshi communities are actively included or tacitly excluded.

- **“Multilingual healthcare professionals should be encouraged to speak local languages”**

Dianne Gardner

Public Health Specialist, Public Health & Wellbeing

Dianne was moved by the engagement and attendance of so many people from the grass-roots. She tanked them for their constructive input and stated that she could not do the conversations any justice with her presentation. Although she was standing in for Kuiama Thompson who unfortunately couldn't make it this morning, but she has sent her best wishes to the participants.

Dianne briefly stated that the Kuiama’s presentation would have highlighted the that Health inequalities are avoidable and unfair differences in health status between groups of people or communities. Our health is determined by our genetics, our lifestyle, the health care we receive and the impact of wider determinants. active. You have in your own ways have already highlighted that in the discussion groups.

- The borough is an increasingly diverse place BUT our data is out of date and incomplete
- Asian/Asian British Pakistani group is largest group 10.5%, after White British.
- 30.3% of deliveries to mothers of BME groups
- Many of our minority ethnic groups also experience highest levels of deprivation
- Latest detailed breakdown of ethnicity is the 2011 Census (2021 results expected later this year)

Hamza Zulfiqar

User voice and experience

“I am from Rochdale, from my early life from primary school to high school and college I had to push professionals to get assessments. I had SEN but I believe I should have ECHP plan in place by the system. But due lack funding and due to my mental health and multiple health and wellbeing challenges (hearing impaired/deaf and recently been diagnosed autism/autistic should been picked up from the start from primary school, they refused to do it since my early childhood to now. I believe I was getting the right point motivation. I wake up in morning and feel I am not heard. Hopwood and Oldham colleges have often brushed the issues under the carpet. In addition I fell I have been pushed to away to one side. The council said college has funding and college wants me to go the council, I feel I am going around in circles and been left behind.

Today if I had the irrelevant help at the right time I wouldn’t been in this situation today: left school with no qualifications , no job and no future aspects . I moved into support living in accommodation in Milnrow 3 years ago now getting social support though adult care. I feel I am not getting enough support due the allocated hours and not receiving emotional support when I need it. Everyone know me as a happy guy who care for everyone especially the community.

if I could get help, other young people like me with learning disabilities would get proper support for employment and mental health support services which should be available. There are lots of people like me who are not getting the support they need and often get pushed around from one agency to another or have our views and experience of mental health, disability, race and dealing with other complex needs brushed under the carpet. Our parents should not have to fight for basic support that their children, they are entitled to basic need and the Government should allow us to have access to basic services to meet our needs as a priority. Thank you for listening and allowing me to share my experience“

Concluding remarks and next steps

Cllr Daalat Ali and Maqsood Ahmad

Cllr Daalat Ali and Maqsood Ahmad concluded by thanking the participants for sharing their experiences and knowledge during the roundtable discussions. Without their input this project cannot be successfully so it was vital to hear what Rochdale was doing well but most important of all what we could do better based on your experience and knowledge. Number of issues came up that we need to take on board as the participants outlined in the round table discussions.

Next steps will be to capture via summary of the issues highlighted in a seminar report with recommendations. The report will circulate to the participants and placed on the British Muslim Heritage Centre website, Facebook and Twitter for those that could not attend the seminar this morning.

Cllr Daalat Ali and Maqsood Ahmad both stated that this is a journey we have embarked upon to build on the good work that the communities and organisations are already doing. We will be in touch again via the establishment of the tackling health inequalities network which many of you have indicated would eb beneficial.

Recommendations

1. Develop a training and awareness pack for the Kashmiri, Pakistani and Bangladeshi communities to better understand health inequalities and what they can do themselves to tackle some of the inequalities they way at a local level. The training pack should include sign posting of existing mainstream and voluntary services that will support them in tackling health inequalities
2. Organise training the trainers sessions (women, men including imams and young people) so that the training and awareness can be cascaded down to local groups.
3. Establish a tackling health inequalities network that meets at least three times a year. The network aim of the network should be to act as a bridge between the communities and professionals, provide an opportunity to have a better understanding of how decision are made and increase mutual awareness. Example could include inviting speakers such as GP representative to hear the issues facing the communities in accessing GPs, Public Health Directors to update on local policies to sharing good practices and partnership projects that are making a difference to local people.
4. The Council and Public Health Director to explore the possibility of having better local targeted diversity data based on the local population and meaningful information on those communities that will assist in targeting communities that are most effected by health inequalities.
5. That local media including social media be utilized to get the message on tackling health inequalities to the local people in local languages.

APPENDIX !: PROGRAMME

TIME	SESSION	SPEAKERS FACILITATORS
9.30am	Registration, Tea and Coffee	
10.00am	Welcome, introductions and aims of the seminar.	Maqsood Ahmad Chief Executive
10.10am	Council commitment to tackling health inequalities.	Cllr Daalat Ali
10.20am	Tackling health inequalities - a partnership approach	Abdul Hamied Deputy Director
10.30am	Round table discussions: session 1 What's your understanding of health inequalities and what influences health inequalities?	Dr Fatima Khan Maqsood Ahmad
10.40am	Feedback from tables	
11.00am	Refreshment Break	
11.20am	Round table discussions: session 2 How can we tackle health inequalities on an individual and community level?	Dr Fatima Khan Maqsood Ahmad
11.40am	Feedback from tables	
12.00pm	Tackling Health Inequalities - what do we know so far… experience, research, facts etc	Kuiama Thompson
12.15pm	Questions and Answers session	Maqsood Ahmad
12.30pm	Concluding remarks, next steps and lunch	Cllr Ali Maqsood Ahmad

Appendix 2:

Supported by Rochdale community groups and organisations