

Racial Health Inequalities in Nottingham and Nottinghamshire: Local Routes to Change



1. Foreword

As Co-chairs of the Nottingham City Place-Based Partnership (PBP) Race Health Inequalities (RHI) Programme, we are delighted to present this report. It is the culmination of a period of extensive work over the last 3 years addressing inequalities in health outcomes in the city, which has been both challenging and exciting in equal proportions. Under the executive sponsorship of Jules Sebelin and the Nottingham Community and Voluntary Service, the PBP RHI group has convened professionals from the NHS, local government, voluntary sector and community leaders to collectively look at how together we can make a difference.

This work was propelled out of the converging of social justice issues of global magnitude that made it imperative for this work to take flight at the time it did. Nottingham City PBP leaders has already agreed the need for a dedicated focus on addressing health inequalities in minority ethnic communities and in the midst of a global health crisis caused by the COVID-19 pandemic, it was clear the disproportionate impact this was having on black and brown people and the widening of health inequalities. Finally, there emerged a global recognition of institutional and systemic racism following the tragic murder of George Floyd in the USA by a police officer offer in 2020. This serendipitous backdrop brought the RHI group's mission into focus and made it even more urgent and more meaningful in those early days.

In bringing together such a diverse group we had to be vulnerable to face our own biases, prejudices, maladroit language and long-standing frustration at the slow pace of change. Certain mantras came into view as the group formed such as, *'if not now, when?'* and *'if not you, who?'*. There was a clear consensus that to affect change *'we had to be on the table, otherwise we would be on the menu!'* This wasn't a time for making empty pronouncements with no meaningful commitment or action. It was a moment to engage in real change and to courageously step forward to collectively address these barriers to better health outcomes and equality.

It was considered action that we had to take, and we are delighted to be part of a group that was pivotal in driving change in this area. The RHI group contributed to ensuring culturally competent engagement took place sensitively with our diverse communities, resulting in innovative practice, such as setting up vaccination centres within our diverse faith communities during the pandemic. We developed, established, and rolled out the maturity matrix assessment tool which is helping organisations to improve their cultural competence and responsiveness and address structures and processes that can exacerbate inequalities. We are proud that this work has received national recognition as a shortlisted finalist in the NHS Race Health Equality category of the Health Service Journal Awards 2023.

In one way, the apex of this work was the Race Health Inequalities Summit in May 2023 which was the first of its kind in Nottingham, and this report reflects on the two key areas of health inequality that participants agreed requires urgent attention: maternity care and mental healthcare. Having experienced the high of the Summit we hope that the energy and enthusiasm in abundance that day will lead to long lasting institutional change as outlined in the recommendations of this report. Ownership and investment is required across the members of our Integrated Care System to take this forward. Commitment from leadership in the NHS, local authority, partners and ongoing meaningful engagement with communities will be critical to see this agenda through.

This report is not just a compilation of data and statistics; it is a testament to the lived experiences of individuals who navigate a healthcare system influenced by race health inequalities. It is a call to action, urging us to confront systemic issues, dismantle barriers, and strive towards a future where health outcomes are equitable for all.

We would like to thank Krista Blair for her work in preparing this report, the collaborative spirit of every member of the RHI group and every contributor who played a role in shaping this report. We would also like to pay special tribute to Leslie McDonald and Rose Thompson who we sadly lost in 2023. Leslie was a huge influence on this work, it is likely that without his contribution, much of the work of the RHI group would not have come to fruition. As the original lead for the RHI programme, Rose was instrumental in starting us on this journey – we are grateful to both Leslie and Rose for their contributions. May this report serve as a catalyst for positive change, sparking conversations and inspiring collective action to eradicate race health inequalities in Nottingham, Nottinghamshire and beyond.

Sincerely,
Clive Foster, MBE and Donna Sherratt
PBP Race Health Inequalities Programme Leads



Pictures courtesy of 16th Productions Hauwa Abdulmalik Yusuf

As well as being a senior minister, Clive has held roles tackling hate crime, as an advocate for the Windrush Generation (for which his services have been recognised with an MBE), and as Executive Dean for Equality, Diversity, and Inclusion at Nottingham Trent University. These roles have provided Clive with a unique perspective on the challenges faced by ethnically diverse communities. The experience of being recognised with an MBE for services to the Windrush Generation further underscores the importance of acknowledging and rectifying historical injustices. Change doesn't happen by hope but by, "high intention, sincere effort and intelligent execution".

Donna has been instrumental in bringing her systems thinking acumen to this agenda specifically in the development of the maturity matrix. The success of the matrix is testament to Donna who has worked in the early intervention and prevention arena for over 28 years and became Head of Programme at Small Steps Big Changes in September 2018. This role has enabled her to follow her passion for making a difference for families. This work also led to Donna being nominated as a member of the Nottingham and Nottinghamshire Integrated Partnership where she represents the voices of the RHI group members. Donna takes inspiration from those who lead the way such as Roy Hackett who said, "you have to be in it to change it" which is what Donna truly personifies and this work is indebted to her contribution.

2. Introduction

2.1. About this report

This report discusses racial health inequalities in Nottingham and Nottinghamshire, and how local organisations and community members can contribute to reducing health disparities.

The report draws on the discussions that began at the Race Health Inequalities Summit on 11th May 2023 in Nottingham. Following this event, some of the attendees, both from the public and voluntary sectors, participated in three further workshops exploring the causes of, and possible responses to, local health inequalities. Individual stakeholders also shared research and other evidence they had on racial health inequalities.

Both the Summit discussions and the follow-on workshops focussed on maternity health and mental health, and the report maintains this focus. Whilst the report draws on existing research on health inequalities, it is not intended as an evidence review. Rather, the aim is to summarise stakeholders' collective insights into the problem at local level, and the opportunities for action they have identified.

The first section of this report discusses disparities in health outcomes and experiences of care for racially minoritised communities, focussing on Nottingham and Nottinghamshire. Following this, it reviews local stakeholder intelligence on the factors contributing to racial health inequalities in our locality. The final section discusses potential actions that organisations and community members can take to help tackle racial health inequalities.

3. Racial health inequalities: situation summary

3.1. Racial health inequalities in England and the social determinants of health

Racial health inequalities are part of a wider picture of inequality in Britain, in which poorer health outcomes are associated with deprivation and social inequality. Since 2010, health inequalities have widened: people in the least deprived 10 per cent of neighbourhoods have seen increases in life expectancy, whereas many of the most deprived neighbourhoods in England have seen decreases in life expectancy (Marmot et al. 2020, p.13). Minoritised communities are particularly hit by this growing inequality, with a greater proportion of minority ethnic children living in poverty than White British children (Marmot et al. 2020, p.42).¹

The overall picture of inequalities in health outcomes is complex, with different ethnicities, including White ethnicities, having higher rates of diagnosis for different diseases. However, there are higher levels of diagnosed ill health for Pakistani, Bangladeshi, and Black Caribbean ethnicities than for White ethnicities² (Watt et al. 2022). There are also ethnic disparities in access to care and patient experience (Magadi and Magadi 2022), with Asian ethnicities reporting poorer experiences accessing primary care than White or other ethnic groups (Fisher and Fraser 2020).

For both maternal and mental health outcomes, there are inequalities amongst ethnic groups. For example, there is a greater risk of mortality for mothers from ethnic minority backgrounds compared to White mothers, with maternal mortality for Black women almost four times higher than for White women (House of Commons 2023, pp. 3-4). Being Black or South Asian puts a mother at risk of poorer birth outcomes (stillbirth, premature, and low birth weight) (Li et al. 2019; Jardine et al. 2021), with the most socioeconomically deprived Black and South Asian women having the worst outcomes (Jardine et al. 2021).

Similarly, there are differences in the recorded prevalence of mental health conditions amongst ethnic groups in England. Common mental disorders such as anxiety and depression are more prevalent amongst Black women than other women; and psychotic disorders are estimated to be more than ten times as prevalent amongst Black men compared to White men (Cabinet Office 2018, p. 49).³ Understanding actual prevalence is complicated, however, as racial disparities may figure in the stage at which person is diagnosed and the treatment they receive.

There are also disparities in access to and outcomes from mental health treatment. Compared to other ethnicities, Black adults in the general population are the least likely to report being in receipt of treatment. Some ethnicities have better outcomes from mental health treatment than others, with White patients more likely to see a recovery from psychological therapies than other ethnicities, and Bangladeshi, Pakistani, Other Asian, and Other ethnic groups least likely (Cabinet Office 2018, p.50).

Whilst not a single ‘racial’ category, we note that despite a relatively young age profile, asylum seekers and refugees nevertheless have high health needs, with some evidence that health deteriorates in the first few years following arrival in the U.K. (Fassil 2002 cited in Yakubu et al. 2018). Two key areas of health needs for this group are maternal and mental health, with evidence of poorer maternal health outcomes and high prevalence of mental health conditions (Heslehurst et al. 2018; Yakubu et al. 2018; Nair et al. 2015 cited in Nellums et al. 2018; Robertson, Bondareva, and Aspden 2020).

3.2. The Nottingham and Nottinghamshire population

Nottingham is an ethnically diverse city, with just under 43 per cent of its population belonging to ethnic minority groups; younger age groups⁴ and residents of inner-city wards tend to be more ethnically diverse. In contrast, Nottinghamshire is over 88 per cent White British. Across the two authorities, the largest ethnic groups after White British were Asian (6.34%), White Others (5.72%), and Black (3.67%).

Healthy life expectancy for both men and women in Nottingham (across all ethnicities) is significantly below the England average.⁵ The prevalence of both stillbirths and maternal obesity for the population is higher than the England average (Nottingham City Council 2018; 2019).

Whilst, as we would expect, many members of Nottingham’s ethnic minority communities have been resident in Britain for generations, racially minoritised people also include recent migrants. Migrants can experience disadvantages specifically linked to their migration (IOM 2019). At the time of the 2011 Census, about 20 per cent of Nottingham’s population were foreign-born, though not all these individuals would have belonged to ethnic minorities (Krausova and Vargas-Silva 2013). In 2016, 37.9 per cent of Nottingham’s births were to mothers born outside the U.K.

In Nottingham and Nottinghamshire, available data and local stakeholder intelligence suggests a similar picture compared to that nationally for racial health inequalities, with inequalities both in people’s health outcomes and their access to and experiences of health services.

¹ Whilst acknowledging that race and ethnicity are not the same, this report uses these interchangeably in many cases, as it draws on sources with varying definitions of these social identities; where racial groups are referred to, these relate to the categories used in Census data, which incorporate racial, cultural, and national identities.

² When standardised for age distributions.

³ Some studies have also found disparities in mental health outcomes amongst ethnic groups for one gender but not the other (e.g. Burton, Hadid and Denness 2017).

⁴ Nottingham has a relatively young population, reflecting the presence of two universities, though this is not the only reason for a young population (Burton et al. 2017).

⁵ This section draws on analysis of 2021 Census data in the Nottingham and Nottinghamshire JSNA, Chapter 1: Health and Wellbeing.

3.3. Disparities in health outcomes in Nottingham and Notts

A 2015 study of Nottingham City found that although BME residents were less likely than non-BME residents to report poor health, this was due to the younger age profile of the City's BME population, and that for those over 50, BME residents were more likely than non-BME residents to report poor health (Bamont et al. 2015).

There is a need for further evidence to better understand local inequalities in mental ill health and poor maternal health outcomes. For example, whilst the Nottingham Citizens' Survey suggested that people from BME groups had less poor mental health than those from white or mixed backgrounds, this contradicted ONS findings (and other research) and may have been due to attitudes in some communities towards mental health (Burton, Hadid and Denness 2017, p. 121). A recent local analysis found that, as with the national picture, disparities in recorded health outcomes amongst ethnic groups varied: Mixed patients were 1.4 times more likely than White patients to be diagnosed with severe mental illness, but Asian patients were 43 per cent less likely to be diagnosed with severe mental illness than White patients.⁶

3.4. Disparities in receipt of and experiences of care

Local organisations report local inequalities in access to care and experiences of care, and there is some local data on this. In Nottingham City, both Black and Asian patients were less likely to receive primary care, to attend A&E, or to attend cervical screening compared to White patients. Black and ethnic minority citizens consulted as part of a BME health needs assessment described difficulties accessing GP services and feeling services were not responding to cultural needs (Burton et al. 2017). The Nottingham and Nottinghamshire Refugee Forum have produced a report describing multiple barriers to accessing healthcare and poor experiences of care for local refugees and asylum seekers (Robertson, Bondareva, and Aspden 2020)⁷.

In relation to mental health, a 2017 health equity audit identified lower rates of access to talking therapies by Asian and Mixed ethnic groups in Nottingham City (Johns 2017), with a more recent analysis of 2021 data (presented at the Race Health Inequalities Summit), similarly showing an underrepresentation of many minoritised ethnic groups. This is similar to the national picture (Kapadia et al. 2022, p.88). Prior local consultation with minoritised residents found that people thought that not only were mental health needs common in their communities, but that this was exacerbated by discrimination and barriers to accessing services (Burton et al. 2017, p. 6).

An independent review of care at Nottingham University Hospitals maternity services was established in 2022 and continues. Whilst there is limited local research on access to and experiences of maternity services for minoritised women, several recent national reports highlight dissatisfaction by women from minoritised ethnicities with their access to and treatment by maternity services (Parkin and Balogun 2023).

The next section of this report discusses how different factors identified by local stakeholders and organisations are thought to be contributing to inequalities both in minoritised people's health and their healthcare.

4. Drivers of health inequalities

4.1. Drivers of racial health inequalities: thinking beyond health services

Both at the Summit and in subsequent discussions, stakeholders from Nottingham and Nottinghamshire's public and voluntary sector organisations identified three broad sets of factors contributing to racial health inequalities:

- wider social, economic, and political inequalities, which affect how people live. These are sometimes termed the social determinants of health⁸;
- the ways in which health services are designed and delivered, including health professionals' understanding of, and relationships with, minoritised communities; and,
- the experiences, information and resources, and support networks that minoritised individuals and families have or don't have.

The workshop discussions and desk research informing this report explored the contributors to mental health and maternity health inequalities separately. However, the vast majority of the factors identified by local stakeholders as driving inequality were common to both mental health and maternal health inequalities. Figure 1 below summarises the main factors identified by local stakeholders as contributing to both areas of racial health inequalities. In Nottingham and Nottinghamshire, different combinations of these factors act to

- damage people's mental health and wellbeing or their health before, during or following pregnancy;
- stop people from seeking out or accessing healthcare services; and,
- reduce the quality or suitability of the care they receive.

⁶ These figures are based on an analysis by the System Analytics Intelligence Unit at the Nottingham and Nottinghamshire Integrated Care System, of local GP data from eHealthscope, a locally developed tool for clinical practice, examined statistically significant differences amongst ethnic groups. It was presented at the Race Health Inequality Summit.

⁷ By June 2023, there were 1577 supported asylum seekers in Nottingham (House of Commons Library 2023).

⁸ The social determinants of health have been described as 'the conditions in which people are born, grow, live, work and age and inequities in power, money and resources' (Marmot et al. 2020, p.5). These conditions influence a person's opportunity to live healthily and their risk of becoming ill. It has been estimated that healthcare accounts for less than half of a person's health outcomes, with the other factors largely being ones connected to people's life circumstances and behaviours (Local Government Association 2020, p.6).

Figure 1: Factors contributing to racial inequalities in maternal health and mental health, Nottingham and Nottinghamshire

Wider social, political and economic inequalities	Poverty and the struggle to meet basic needs
	Unstable, crowded or indecent housing and unhealthy environments
	Immigration status and its effect on economic and social inclusion and rights
	Digital exclusion/digital poverty
Local health services	Underfunded, rationed health services (waiting lists, thresholds)
	Service fragmentation, inconsistent referral pathways
	Closure of services in the community*
	Inadequate data and insight on care needs and health inequalities
	Service design and delivery not fitting people's culture or circumstances
	Lack of workforce diversity
	Biased attitudes or lack of cultural awareness of staff
	Low or inconsistent involvement of community organisations
Local communities and families knowledge and resources	Lack of English and limited access to interpreters
	Awareness and beliefs about health, including stigmatising beliefs
	Understanding of services
	Distrust or poor prior experience of services
	Power relationships and control over care
	Social isolation

*Identified in relation to mental health inequalities.

4.2. How social, political, and economic inequality contribute to racial health inequalities

Poverty, including indecent housing and poor environments. Poverty and poor, overcrowded housing were described as affecting people’s mental health in several ways: first, poor living conditions and struggling to meet basic needs directly increased the risk of poor mental health or wellbeing. Recent research by Joseph Rowntree Foundation (Clark and Wenham 2022) has identified links between material insecurity and mental distress. In addition to the stress of economic precarity, stakeholders said people were also unable to afford to participate in activities which would support mental wellbeing.

Similarly, poverty and living conditions directly affect a woman’s overall health by making it difficult to have a healthy lifestyle. Poverty and deprivation can also relate to the wider environment or neighbourhood a person lives in; an earlier consultation found that conditions in Nottingham neighbourhoods where minoritised consultees lived influenced their participation in physical activity (Burton et al. 2017). A particular area for discussion at the Summit was the effect of air pollution on maternal health, which the World Health Organisation identifies as the second highest risk factor for noncommunicable disease and a cause of preterm and low birthweight (WHO 2023). (All Nottingham City is an air quality management area unlike much of the County)⁹.

Referring to the way in which deprivation and poor public health puts minoritised women at risk, one Summit attendee pointed out that maternity outcomes need to be seen as a wider issue than maternity care: ‘Maternity care is not going to be able to fix these problems in a nine-month period.’

Stakeholders argued that poverty could also affect access to help for health conditions: for example, parents of young people struggling with their mental health might not recognise their child’s mental health needs or respond to these because of the demands of meeting basic needs. One stakeholder working with very disadvantaged people said that when people were struggling to meet their basic needs (e.g. food, shelter), they prioritise obtaining these basics rather than seeking help for their mental health. Stakeholders also said that income can act as a barrier to women accessing maternity care or benefitting from that care: women could be unable to afford to travel to attend appointments or to take the time off to attend these, or be able to afford to buy the things that midwives have advised them to have.

“... if you’re a professional within maternity ...they’re not necessarily going to tell you they’ve [not] got access to wi-fi, they’re not necessarily going to tell you that they’ve got a job appointment...it’s all linked back to finance. They’re not necessarily going to tell you that when a baby arrives, they’re not going to have enough money to be able to put gas on [and] even if they did tell you, what can you do?”

⁹ More information on Air Quality Management Areas is available at <https://www.nottinghamcity.gov.uk/information-for-business/environmental-health-and-safer-housing/environmental-health-and-safer-places/air-pollution-and-air-quality/>

Digital exclusion and poverty. Digital exclusion was identified by some stakeholders as one of the consequences of poverty, with people being unable to afford data or equipment. (Digital exclusion was also described in relation to English language skills.) It was pointed out that much health information, including people's maternity health information, and appointments systems, were going digital. Some stakeholders thought that this was not a significant problem or one that was still emerging. There is some evidence for healthcare inequalities related to digital exclusion, though this varies across groups, settings and services (Kapadia et al. 2022).

Immigration status. Refugees and asylum seekers often face discrimination when trying to access primary or secondary healthcare, and both they and healthcare staff may not know their entitlements, including to maternity care (Robertson et al. 2020). This is exacerbated by changes in people's immigration status, which in turn changes their entitlements to free healthcare. For some, lack of entitlement (or thinking they had no entitlement) to free secondary care, and inability to pay for care, results in no access to healthcare (e.g. Nellums et al. 2018):

"Some people are not part of the system, they can't get access to certain things. They're just non-people really, if that makes sense."

Stakeholders also noted several factors linked to immigration that directly affected mental health. Lack of basic needs was sometimes related to immigration status; moreover, local stakeholders expect recent changes in asylum support regulations to result in people experiencing sudden and acute housing need when their immigration status changes. Some refugees and asylum seekers have experienced trauma, which requires specific mental health support.

3.3 The role of services in racial health inequalities

Underfunded, rationed services. Inconsistent or fragmented referral pathways. Whilst it was recognised that problems with the resourcing and organisation of healthcare affects all patients, stakeholders argued that the effects on minoritised groups were disproportionate. As will be described in section 3.4, minoritised communities may have unequal knowledge of and means of engaging with services. People described both mental health and maternity services as stretched. Rationing was described in the form of waiting lists, penalising policies 'three strikes and you're out', and eligibility criteria.

In addition to rationing, there is fragmentation of services, with inconsistent referral pathways, and different parts of Nottingham and Nottinghamshire having different services. Prior research attributes some of the dissatisfaction of minoritized mental health patients with accessing care as linked to issues around how services are organised (Kapadia et al. 2022).

Service design and delivery not fitting people’s culture or circumstances. Inadequate data and insight on communities’ needs. Stakeholders said that when people are planning services they may not have enough information about different people’s circumstances and needs. Stakeholders commented on a need for more qualitative data and research on the needs and priorities of communities, including direct input from people with lived experience.

In workshops, there was considerable discussion on how to design services that could respond to people’s cultures and particular circumstances. One person observed that planners don’t consider the time and money of the person attending the service when they are looking at the business case for service changes:

“If you’re changing things between City side and QMC and moving services around, have they considered that people who are attending their clinic, actually the majority of them live in X part of the City?”

Stakeholders discussed the need for more to be done to enable and empower healthcare staff to be able to flex and respond to people’s needs:

“You don’t necessarily feel confident to go against the system even though you know that the outcome will be better for the person that you’re supporting. There are many times when you say, “I’m so sorry, I’m giving you this information, and I know you don’t understand English and it’s not relevant to you because you’ve clearly not got the same skin tone as what I’m showing you, but I have to give it to you anyway to tick a box.”

Discrimination, biased attitudes and lack of cultural awareness of healthcare staff. Racial or ethnic discrimination and bias was one of several problems that stakeholders described as affecting health in myriad ways. Prior research conducted in Nottingham found that some refugees and asylum seekers had experienced discriminatory treatment by healthcare staff based on their immigration status (Robertson et al. 2020).

Stakeholders reported that biased attitudes affected people’s access to healthcare, either through people not recognising the minoritised person needed help or by denying help when the person sought to access services. One stakeholder described, for example, how bias could lead Black youths with mental health needs to be seen simply as having ‘bad behaviour’ or – even when mental health problems were recognised – staff in schools not engaging with the person or their family because they don’t feel confident about different cultures.

Discriminatory speech or behaviour can also affect delivery of care, something reported in a number of studies of maternity care for immigrant women (e.g. Higginbottom et al. 2019). Lack of cultural awareness can mean that healthcare workers fail to tailor health advice or care to a person’s culture: stakeholders described how midwives can fail to take an expectant mother’s religion or culture into account, something also reported in studies of maternity services in the U.K. (Firdous et al. 2020).

Lack of workforce diversity. Stakeholders described both mental health and maternity workforces as lacking in diversity, contributing to the problem of low cultural awareness within services. Available existing local data on the maternity workforce (midwives and doctors) shows a less diverse workforce than the City's population. At national level, whilst the workforce overall is more diverse than the general working age population, managers and senior managers are less diverse than within many clinical roles¹⁰.

Closure of services in the community. Low/inconsistent involvement of community organisations. Whilst there is a need for other services to support the NHS and facilitate access, some thought that not enough community groups were involved in this. It was also commented that health sector professionals may not respect the expertise of community organisations, with one person recounting comments that healthcare staff would not refer patients to their service as they 'did not understand' their work.

3.4 How inequalities in knowledge, awareness and social networks contribute to health inequalities

Lack of English and English language interpretation. 8.9 per cent of Nottingham households have no one who speaks English as a main language in the home (but may speak English outside); 3 per cent cannot speak English well or at all (Nottingham City Council 2022). Poor English language skills were described by stakeholders as contributing to a risk of ill health, lack of access to healthcare, and poor quality of care in multiple ways. Without English language skills or sufficient access to quality interpretation, both expectant mothers and those with mental health needs could have insufficient information about the availability of and their entitlements to both healthcare and to other help that could improve their living conditions (e.g. financial help). People can experience difficulties communicating about appointments, and when they are seen, the care they receive suffers due to poor communication. One stakeholder described a new mother's pain and injury from breastfeeding going unaddressed by a midwife because the mother hadn't been able to communicate what was happening.

A range of comments from stakeholders indicated a need for more interpreters: people said that interpreters can be involved too late in the process or be of poor quality; can be from the same community, compromising privacy; or may be male, which can be inappropriate. People referenced cases of interpretation in labour being delivered over the phone by a man, or interpretation being provided by family. It was also noted that 'form-based' processes are particularly hard for communities where English is a second language. This feedback aligns with research on minority groups' experiences of mental health and maternal healthcare, which identifies that language barriers and lack of access to interpreters affects access to mental health services and, for maternity care, the quality of the care received (Higginbottom et al. 2019; Kapadia et al. 2022).

¹⁰ NHS Workforce Data June 2022 available at <https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#by-ethnicity-and-grade-managers-and-senior-managers>

Awareness and beliefs about health, including stigmatising beliefs. A number of stakeholders described how different communities could have attitudes towards or understandings of health that could stop them from seeking help or following the health advice or treatments they were given. In some communities, maternal and mental health may not be discussed by a person's peers. One stakeholder commented that shame and stigma around mental health problems are experienced across many communities, and that they themselves had once not understood that depression was a disease:

"I always thought depression did not exist, until I went to the training, and I realised ...I was always thinking, there are problems in the world, they are created in the world and will remain in the world ...I always thought, why don't you just ignore it? ...And then I'd been to the training, and that changed my thinking and my perspective towards that."

Other examples of how awareness and knowledge about health affects seeking care or benefiting from care were:

- *people may not be familiar with treatments such as talking therapies;*
- cultural expectations can clash with health advice: the way someone cooks influences how they interpret and can use health resources such as the NHS Eat Well guide;
- people may lack health information that enables them to know when they should seek help e.g. they don't recognise the symptoms of hypertension or gestational diabetes; and,
- some public health information can appear to be targeted at White groups, rather than racially minoritised groups.

Lack of understanding or distrust of services. Stakeholders described how when people don't understand NHS health services or what is available, it stops them from accessing services: 'Who does she tell when she's pregnant and when? Who does she contact if she experiences problems? How does she re-arrange appointments?' Moreover, if someone is unfamiliar with health professionals' roles or health practices, they may not trust them. One stakeholder described working with mothers who did not understand the role of midwives as they were not part of the health system in their countries of origin. For minoritised people struggling with their mental health, distrust can be rooted in past negative encounters with services:

"By the time they come to us, they have accessed so many services, and they think, 'What's the point?'"

Power relationships and control over care. Stakeholders described how bias, healthcare workers' lack of cultural awareness, and communication barriers could all prevent people from minoritised communities having control over their care. Some described how healthcare workers could reinforce family power dynamics by engaging with the spouse who had better English, rather than the expectant mother

Social isolation. There is strong evidence linking social isolation and loneliness to poor physical and mental health outcomes (NHS Digital 2021). Whilst people from all communities can experience loneliness and isolation, stakeholders also described problems linked to some groups' circumstances. Some minoritised groups, including asylum seekers, who have migrated or who are intentionally dispersed and cannot choose where to live, are at risk of isolation because of their separation from their original family or community (Robertson et al. 2020, p.4). Social isolation was also linked by stakeholders to lack of English language, exacerbating the challenges encountered by new mothers from minoritised communities:

"Because there's so many different people from so many different countries in Nottingham that situation [social isolation] comes up again and again. ...The impact on the person, not being able to communicate your feelings or what you're going through, or understanding what your rights are or what support is available, and that impacts your mental health a lot ...just [not] even knowing that someone else has felt the same."

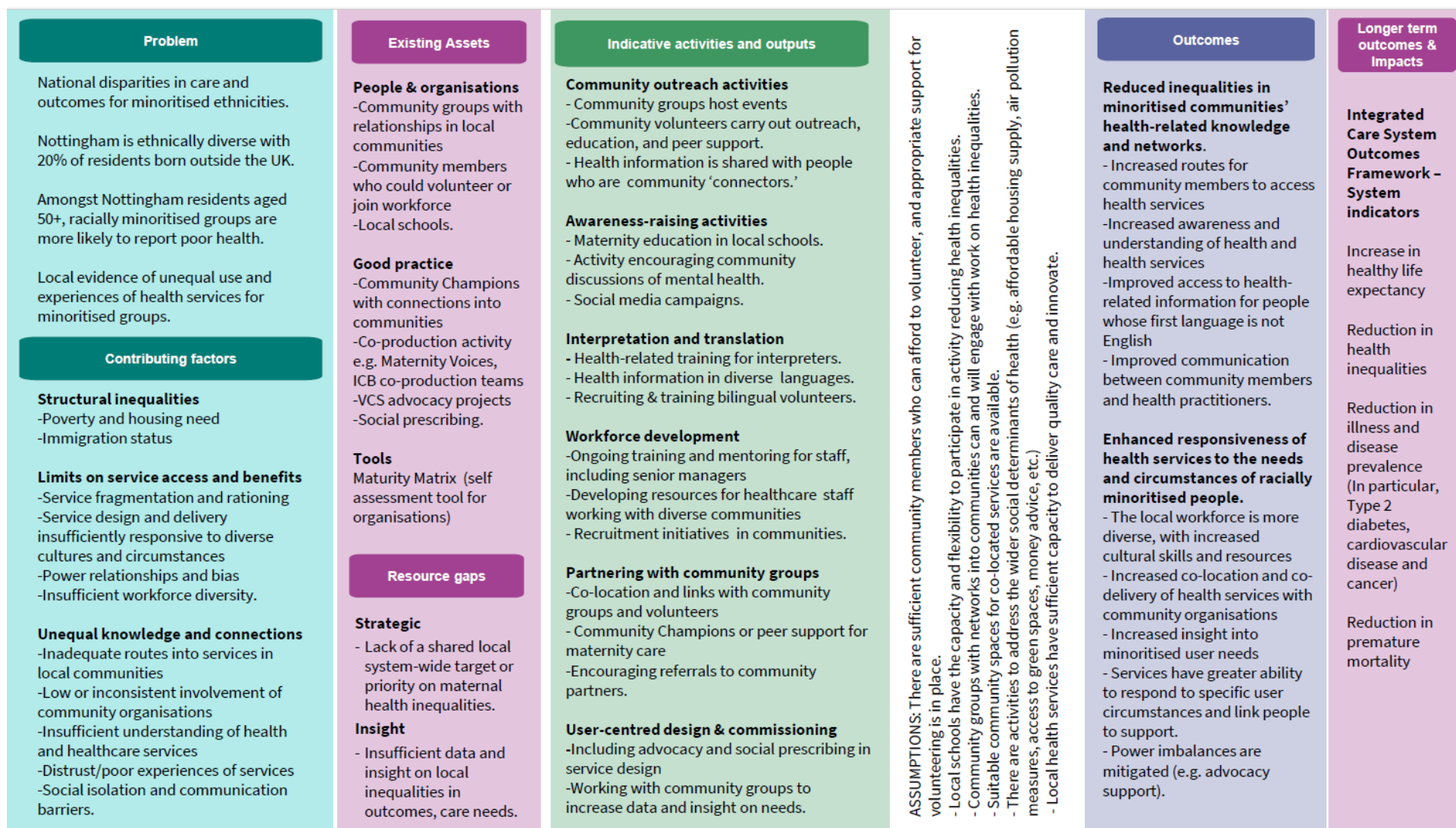
As well as contributing to health problems, stakeholders described social isolation as contributing to people not knowing what services were available or how to access them.

Even when an individual is well supported by their family and community, others in their community may not be able to link them to the help they need, due to language barriers, lack of trust in or understanding of services, or the community's own understanding of how to address a health problem. For instance, one stakeholder commented that fellow community members might encourage a person struggling with their mental health to talk to their pastor, priest, or another community member rather than a health professional. In other words, the wider group is not well connected to healthcare professionals.

Figure 2 summarises how different issues were described as affecting health; as discussed, many issues were thought to contribute to health inequalities in several different ways.

Figure 2: How different factors affect opportunities for healthy living, access to health care, and quality or appropriateness of care.

Factors identified by local stakeholders		Healthy living	Help seeking and/or access to services	Benefit obtained from services
Wider inequalities	Poverty and the struggle to meet basic needs	X	X	X
	Unstable, crowded or indecent housing	X		
	Immigration status	X	X	X
	Digital exclusion/digital poverty		X	
Local health services	Rationed services (waiting lists, thresholds)		X	
	Service fragmentation, inconsistent referral pathways		X	
	Closure of services in the community		X	
	Inadequate data and insight on needs, inequalities			X
	Fit of service design and delivery to community circumstances			X
	Lack of health sector workforce diversity			X
	Biased attitudes or lack of cultural awareness of staff	X	X	X
	Low/inconsistent involvement of community organisations		X	
Local communities and families	Lack of English and limited access to interpreters	X	X	X
	Awareness and beliefs about health, stigma	X	X	
	Understanding of services		X	
	Distrust or poor prior experience of services		X	
	Power relationships in families			X
	Social isolation	X	X	



ASSUMPTIONS: There are sufficient community members who can afford to volunteer, and appropriate support for volunteering is in place.

- Local schools have the capacity and flexibility to participate in activity reducing health inequalities.
- Community groups with networks into communities can and will engage with work on health inequalities.
- Suitable community spaces for co-located services are available.
- There are activities to address the wider social determinants of health (e.g. affordable housing supply, air pollution measures, access to green spaces, money advice, etc.)
- Local health services have sufficient capacity to deliver quality care and innovate.

RHI programme Logic Model

5. Enablers of equality

Stakeholders at both the Summit and subsequent workshops were asked to consider what could be done to address health inequalities. This section describes actions identified by stakeholders that could begin to address some of the causes of health inequalities. Just as many of the identified barriers to maternity and mental health equality were the same, there was a great deal of overlap in the proposed actions.

Whilst most of the proposed actions are not explicitly focussed on addressing wider social and economic inequalities, stakeholders were clear that it was vital to address issues such as food poverty and housing need, which have become increasingly acute in the local area, in order to prevent future health inequalities.

5.1. Enabling services to better respond to minoritised people's culture and circumstances

Support for a more inclusive, culturally aware workforce.

- The existing workforce could become more diverse by developing better pathways for minoritised communities into the NHS. For example, if local minoritised people were supported and trained to volunteer, this could then lead to some people going on to paid work within healthcare. Two suggestions were to build awareness of opportunities via recruitment drives in local communities and to support local people to train via bursaries.
- At the same time, staff should be supported to develop more inclusive practice. Some argued that cultural competency/unconscious bias training for senior staff and managers should be prioritised, as they have a responsibility to lead on this and guide others' development¹¹. Training to address bias must not be a 'one-off' but, rather, part of ongoing staff development and supervision: it should be seen as a journey. There needs to be space for people to say they don't understand and to encourage staff to educate themselves. Alongside recognising the value of advocates from the community, it was noted that minoritised patients having a voice was everyone's responsibility. Similar training for maternity healthcare staff has been suggested by other groups (Nottingham and Nottinghamshire Maternity Voices 2022).
- One stakeholder suggested that whilst a representative workforce is the 'gold standard,' staff should also have access to resources to help them understand the cultural norms of local minoritized communities. Another suggestion was that healthcare staff have opportunities to hear directly from community organisations and, particularly in the case of mental health, people with lived experience.

Delivering services in partnership with community groups. Several proposed actions focussed on developing more co-produced services situated in the community and developing more partnerships.

- By working with volunteers and community partners who have links into and knowledge of local communities, services could be easier for local people to access and navigate. For example, maternity services could be easier to navigate if co-located in community spaces. Also proposed was an updated directory of services, and specific cooperation with local groups/volunteers enabling them to signpost people to the correct services.
- Services should include more co-produced and community-delivered provision; for example, the role of Community Champions or peer support groups in maternity care could be explored. Alternative approaches to health services or complementary services could be delivered by community organisations. For example, bilingual doulas were described as providing complementary (nonclinical) maternity support.
- At the same time, when community-delivered provision is commissioned, healthcare staff should to be encouraged and enabled to refer patients to VCS provision.

User-centred service design and delivery. Services need to be designed to enable healthcare staff to have flexible responses to people's individual needs. A number of people said that more advocacy services are needed to ensure that minoritized individuals are able to both access help, and to make their needs known.

- Stakeholders said that there needed to be more data and insight into the needs and priorities of minoritised residents, and that this could be gained by involving more members of minoritised communities in planning e.g. via forums, but also by leveraging the expertise of community organisations.
- Social prescribing or similar models could enable practitioners to link people to economic support.
- Proposals for advocacy services in the community included advocacy roles in schools and support workers based in community groups. In relation to maternity services, one suggestion was that bilingual doulas could be recruited and trained from local communities.

5.2. Addressing inequalities in knowledge and networks in local communities

Create multiple ways for people to connect to help. Some stakeholders described a need for multiple routes into services, to take account of people's different situations and preferences.

- Several suggestions for raising community awareness of services, and supporting referrals to health services, were for community and social activities that would

¹¹ Mandatory race training for decision makers in all healthcare bodies was recommended by the British Medical Association in its response to the Race Report produced by the Government's Commission on Race and Ethnic Disparities (BMA 2021).

have the added benefit of reducing social isolation. Suggestions included community groups who already had footfall holding open days or workshops with information on health and attendance by health services, and coffee mornings for women that would provide both information and social support.

- People proposed recruiting and training community volunteers to carry out a range of outreach activities, including signposting, health education, and peer support.
- It was pointed out that there are people in the community who already have roles in disseminating information to different communities, and they need to be engaged with information on healthcare services.

Raise awareness of maternal and mental health in minoritised communities.

- Maternity education for women and girls could be provided in local schools, to help raise awareness of topics that are not often discussed. This would ensure that women were aware of maternal health issues and their healthcare rights before they were having a baby. It was thought that some schools already have mental health programmes.
- Actions to encourage wider community discussion of health, including mental health and stigma, could include open days, outreach by volunteers, and producing more materials in community languages.
- It was suggested using social media to directly reach people in communities who are struggling with mental health.

Bridge the language barrier.

- A recurring observation was the need for more and better interpretation: it was suggested there be specific training for interpreters working in mental health settings.
- One stakeholder suggested community organisations could develop information in different languages.
- Several suggestions were made for training and supporting bilingual community members to carry out nonclinical roles, as they could both bridge language barriers and cultural barriers. Bilingual nonclinical roles were previously recommended by a working group on maternal health (Nottingham and Nottinghamshire Maternity Voices 2022). At the same time, it was recognised that people may also prefer to speak to someone not from the local community. Suggestions included both developing volunteer roles and paid roles. In relation to volunteering, whilst this was often mentioned, it was also commented that volunteering requires support and training; that economic priorities e.g. paid work can deter people from volunteering; and that some roles make substantial demands on people.

6. Recommendations

Figure 3: Addressing the local contributors to health inequalities in services and communities.

Services don't respond to minoritised people's circumstances	Support a more inclusive, culturally aware workforce	• Cultural competency training for senior staff and managers
		• Ongoing training and mentoring/supervision for staff to address bias
		• Resources for healthcare staff on traditions and cultures of different communities
		• Recruit from local communities, help to train as midwives and nurses
	Deliver services in partnership with community groups	• Make maternity services easier to navigate via co-location in community spaces, an updated directory, and links to local groups/volunteers
		• Explore role of Community Champions or peer support groups in maternity care
		• Encourage referrals to commissioned VCS services
	User-centred service design	• Work with community organisations to gain insight into people's needs
		• Invest in social prescribing or similar models to link people to economic support
• Support advocacy services in the community e.g. doulas, school counsellors, support workers		
Communities have unequal access to knowledge and connections	Create multiple ways for people to connect to help	• Raise community awareness and support referrals via open days and coffee mornings
		• Train and support community volunteers for outreach & signposting, education, peer support
		• Work with people who can disseminate information on healthcare services to communities
	Raise awareness of maternal and mental health in minoritised communities	• Encourage maternity education for women and girls in local schools
		• Encouraging community discussion of mental health
		• Use social media to reach people in communities who are struggling with mental health
	Bridge the language barrier	• Invest in specific training for interpreters in mental health settings
		• Ensure information is available in different languages
		• Train and support bilingual community members to volunteer

7. References

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Acknowledgement

Authorship and preparation of this report was conducted by Krista Blair from KMB Consulting on behalf of Nottingham City Place-Based Partnership. Nottingham Community Voluntary Service provides executive sponsorship of the Nottingham City Place-Based Partnership's Race Health Inequalities programme.

