Health inequalities in Birmingham

Barriers encountered in underserved wards in East and West Birmingham

A report by Aston University & Birmingham Community Healthcare NHS Foundation Trust, in collaboration with Citizens UK

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Community Connexions

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Contents

Abbreviations

A&E	Accident and Emergency
BCHC	Birmingham Community Healthcare NHS Foundation Trust
BMA	British Medical Association
BVSC	Birmingham Voluntary Service Council
CIC	Community Interest Company
CRN	Clinical Research Network
ESOL	English for Speakers of Other Languages
ESRC	Economic and Social Research Council
GP	General Practitioner
HEIs	Higher Education Institutions
ICB	Integrated Care Board
ICS	Integrated Care System
NHS	National Health Service
PALS	Patient Advice and Liaison Service
PPIE	Public and Patient Involvement and Engagement
UKRI	UK Research and Innovation
VCFSE	Voluntary, Community, Faith, and Social Enterprise

Foreword

This report focuses on the health and wellbeing of residents living in underserved wards in East and West Birmingham. While Birmingham went through a period of economic growth and regeneration, there remains a high number of wards that are characterised by economic and social deprivation. This is particularly true in East and West Birmingham – two localities that are characterised with high levels of infant mortality and childhood obesity, a high number of children in care, and lower educational outcomes. Residents in East and West Birmingham are more at risk of loneliness, more likely to have lower resilience and poorer mental wellbeing, and more likely to die early (Birmingham Health Profile, 2019). People living in East and West Birmingham also face barriers when accessing healthcare and social services, and healthcare professionals in the areas often struggle to meet the needs of the local population.

In this project, we sought to hear from residents who live in underserved wards in East and West Birmingham to capture their lived experiences, shed light on the barriers they face when it comes to living healthy lives, and reflect on possible ways forward.

This report presents findings from an innovative collaboration between Aston University, Birmingham Community Healthcare NHS Foundation Trust (BCHC), and Citizens UK. We are particularly grateful to the following people and organisations for their support: Dr Christine Burt (Birmingham Community Healthcare NHS Foundation Trust), Dr Fatima Zakia (Birmingham Community Healthcare NHS Foundation Trust), Urfan Siddiqi (Birmingham Community Healthcare NHS Foundation Trust), Hannah Ackom-Mensah (Black Country Healthcare NHS Foundation Trust), Saeed Haque (Citizens UK), Tom Snape (Citizens UK), Amy Maclean (Birmingham Integrated Care System), Rehana Begum (Aspire & Succeed), Malieka Selassie (BLESST Centre), Richard Campbell (BLESST Centre), Nasri Meraneh (Huda Community Centre), Meena Bibi (Saathi House), Tiffany Joseph (Saathi House), Mashkura Begum (Saathi House), Shamsun Choudry (Saathi House), Susan Fulford (Age Concern Birmingham), Pete Millington (Age Concern Birmingham), Sam Marsh (Welcome Change CIC), Lauren Kenney (Welcome Change CIC), Victoria Shread (Welcome Change CIC).

We would like to express our heartfelt gratitude to all the participants who took the time to share their views and concerns with us during the listening events – none of this would have been possible without them.

This report aims to capture the voices of communities that have long been underserved and calls for enhanced collaboration between the public and third sectors to come together to help tackle some of the inequalities residents of East and West Birmingham are facing.

Executive summary

Background

This report presents findings from an innovative collaboration between Aston University, Birmingham Community Healthcare NHS Foundation Trust (BCHC), and Citizens UK. The collaborative project aimed to better understand health inequalities in some of the most deprived wards of East and West Birmingham, and launch a series of co-produced initiatives to help tackle some of the barriers that lead to poor health outcomes. For this project, the team held five listening events with underserved communities in East and West Birmingham, and hosted a community sandpit event to co-produce solutions to respond to local health challenges. As a result of this initiative, five follow-up projects were funded to support health and wellbeing among local residents.

The aims of this collaborative initiative were to:

1. Identify local and hyperlocal barriers that lead to poor health outcomes in East and West Birmingham
2. Address power asymmetries in healthcare and capture traditionally underserved voices
3. Propose local and hyperlocal solutions to tackle health inequalities in East and West Birmingham and assess their impact

The objectives of the project were to:

1. Listen to communities that have traditionally been underserved and capture their voices and lived experiences
2. Shed light on local communities' concerns on accessing healthcare services and barriers to health and wellbeing
3. Disseminate findings with the wider health ecosystem to help improve public health services – at the hyperlocal level and within the broader ICS (Integrated Care System) footprint of Birmingham and Solihull
4. Co-produce solutions, pilot community-led projects, and assess the impact of micro-funding on local communities
5. Use the findings to co-design future research projects, with a view to enable change

The first phase of the project (data collection) was funded by UKRI (£6,311 to Aston University via the Policy Support Funding) and BCHC (£3,111 match-funding towards a community sandpit event). The second phase of the project (data dissemination including infographics and videos) was funded by UKRI (£5,500 to Aston University via the Policy Support Funding), Aston University (£5,500 match-funding), and ESRC (£1,960 to Aston University via the Impact Acceleration Award).

Community partners & engagement models

Aston University, BCHC, Citizens UK, and several community-led organisations came together to co-design the project, shape its direction and objectives, collect and disseminate the data. All community-led organisations were located in deprived neighbourhoods in East and West Birmingham, and were member organisations of Citizens UK:

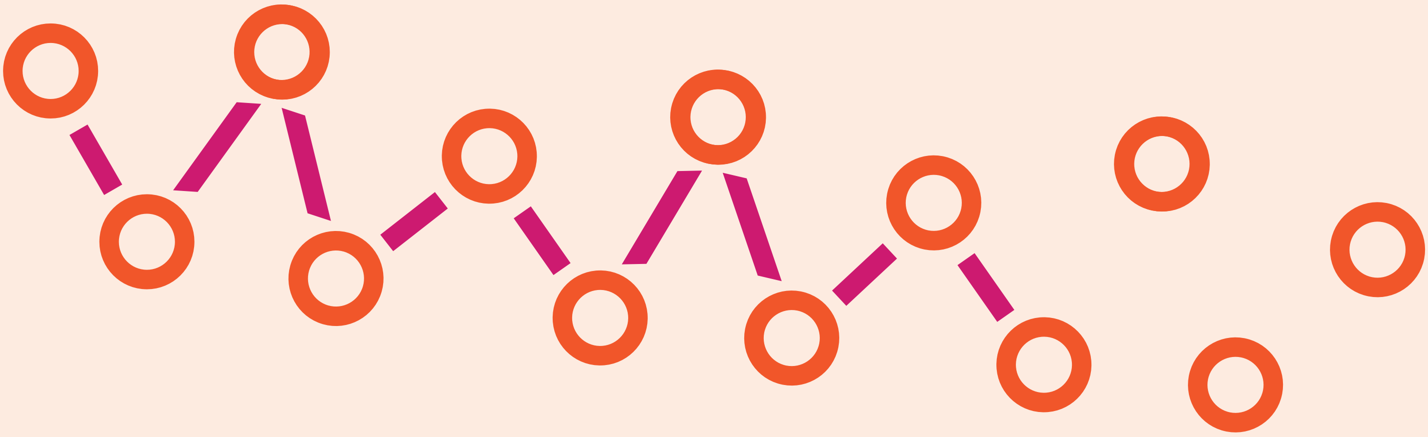
- Aspire & Succeed (located in Lozells)
- BLESST Centre (located in Newtown)
- Huda Community Centre (located in Newtown)
- Saathi House (located in Aston)

The team also held a listening event with students at Aston University (located in Nechells).

After hosting five listening events in East and West Birmingham, the data was presented during a 'community sandpit event'. The sandpit was hosted at Aston University and was attended by all partner organisations, as well as a wider group of community organisations that had expressed interest in being involved in co-producing solutions for residents. These included:

- Age Concern Birmingham (located in Shard End)
- Bringing Hope (located in Handsworth)
- Welcome Change CIC (located in Shard End)

The sandpit event provided an opportunity for community partners to get together to discuss and generate their own project ideas to address local barriers that lead to poor health outcomes in East and West Birmingham. Aston University and BCHC jointly provided £6,390, which supported five projects.



Key findings

Barriers to living healthy lives included difficulties to accessing healthcare services, for example:

- GP accessibility, largely related to the difficulties in getting GP appointments including lengthy waits before receiving an appointment
- Language barriers and lack of suitable translation/interpretation services available
- Lack of continuity of care, and poor communication between different NHS services/departments
- Poor mannerisms or behaviour of NHS staff towards patients (often due to healthcare professionals being tired/spread thin and/or lack of intercultural competence)
- Need to further listen to children and young people who are of school age, in order to offer adequate support and provision

Other barriers related to wider social and structural determinants that affected general health and wellbeing included:

- Local Authority closing down local sports centres and swimming pools in underserved areas, making it more difficult to maintain healthy lifestyles, including for children and young people
- Lack of investment to support voluntary, community, faith and social enterprise (VCFSE) organisations that can act as health champions and promote good health and wellbeing within their locality
- Poverty and cost of living concerns
  (NB: these findings were collected before April 2023, and the cost-of-living crisis)
- Digital exclusion

The report also highlights issues around mental health, and how children, young people and families are left vulnerable, especially since the COVID-19 pandemic. Finally, the report sheds further light on the gender health gap, demonstrating that women are more likely to be the ones who feel unsupported (e.g. antenatal/maternity care), and the ones who encounter multiple obstacles when seeking care for themselves and/or dependents (e.g. paediatric care).

Impact of the project

All project partners benefited from the collaborative approach and complementary expertise of those involved. Every community partner expressed satisfaction that their concerns had been listened to, and that their voices had been heard. However, they also stated that they wanted to see action and hear about progress and impact post-project, as too often they do not see any positive impact after being consulted. The community sandpit event allowed us to do this, as data and proposed follow-up plans were presented by community partners who received funding to generate their own projects to address health issues in their localities. Saying this – we view this report as the beginning of a longer collaborative journey – not the end of a project.

Key findings

Examples of difficulties to accessing healthcare services:

GP accessibility

difficulties in getting appointments and waiting times

Language barriers

and lack of suitable translation/interpretation services available

Lack of continuity

of care, and poor communication between NHS services/departments

Behaviour of NHS staff

often due to tired health professionals and/or lack of intercultural competence

Further listening

required to children and young people, to offer adequate support and provision

Other barriers affecting general health and wellbeing included:

- Poverty and cost of living concerns
- Closure of local sports facilities
- Digital exclusion
- Lack of support for local VCFSE organisations that promote good health and wellbeing

Recommendations

This report ends with a number of recommendations, which are listed below. Many of our recommendations echo those found in the 2022 BLACHIR report, not only highlighting the relevance of their recommendations, but also demonstrating their relevance beyond Black African and Black Caribbean groups. These include:

1. **NHS Trusts to implement compulsory intercultural competence training of healthcare professionals, on a regular basis. The aims are to:**
   - Help rebuild trust, which is currently lacking between minoritised ethnic and racial communities and the NHS (among other public organisations).
   - Help overcome existing biases to tackle discrimination and improve patients' experiences.
2. **The Health and Wellbeing Board to work with the Children's Trusts and Children's Strategic Partnerships to help improve the lives of children and young people. The aims are to:**
   - Make the NHS more visible within community settings so children and young people are increasingly familiar with their presence and the work they do. This can help rebuild trust, and raise awareness of the different services available to children and young people.
   - Support children and young people through key periods of change – not only developmental changes (as highlighted in the BLACHIR report), but also important social changes (e.g. after lockdowns; being able to respond to the current mental health crisis).
3. **Working collaboratively to support healthier behaviours in underserved areas. Our report specifically calls for the Integrated Care Boards (ICBs) to work with Local Authorities to map out existing provision of leisure centres, swimming pools, and other community centres that promote good health and wellbeing. The aims are to:**
   - Identify any gaps in provision, and decide how to respond adequately to ensure all communities have equal access to leisure centres and community centres.
   - Identify existing provision, and assess whether activities are effectively communicated to local communities (e.g. including in languages other than English and in pictorial form), and whether they are tailored to the needs of the local population (e.g. is the leisure centre easily accessible by public transport? Does the centre/swimming pool offer women-only sessions during school hours when women are more likely to be available?).

4

Working with the voluntary, community, faith and social enterprise (VCFSE) sector to increase health literacy among minoritised ethnic groups. Our report calls for the Health and Wellbeing Boards and ICBs to work collaboratively with VCFSE partners. As the BLACHIR report states, "[i]ncreasing people's skills, knowledge, understanding and confidence (health literacy) to find and use health and social care information and services to make decisions about their health is key to achieving healthier communities." (p. 10). The aims are to:

- Respond to participants' feedback, who called for a more holistic approach to health.
- Equip VCFSE partners with the tools to support good health and wellbeing within their communities.
- Work in partnership with VCFSE partners to co-create health solutions, ensuring these are tailored to the needs of the local communities.
- Acknowledge that VCFSE organisations are more likely to be trusted by residents.
- Recognise that VCFSE are more likely to provide culturally appropriate support.

Our report also makes further recommendations:

5

Integrated Care Boards (ICBs) to communicate clearly where the first port of call is for each type of ailment, which services are accessible without needing GP referral, and how to access secondary care via self-referral. Ideally, in pictorial form to make it easy for everyone to access. The aims are to:

- Reduce the burden on health and social care services.
- Attend to patients in a timelier manner.

6

GP practices to review their policies pertaining to telephone/video consultations, and offer more face-to-face appointments – especially where English is a second language. The aims are to:

- Provide more inclusive services.
- Help rebuild a relationship between the patient and the GP, who increasingly seems to be hard to reach.
- Tackle linguistic barriers (participants whose first language was not English explained that they found it more difficult to understand healthcare professionals when not meeting them face-to-face).

7 Medical and wider clinical training to include basic interpretation skills. The aims are to:

- Acknowledge that language barriers can lead to poor health outcomes.
- Equip healthcare professionals with basic skills to support patients whose first language is not English.
- Enhance intercultural competences among healthcare professionals.

8 Regional and Local Authorities to revise how funding is allocated – too often, small voluntary, community, faith and social enterprise (VCFSE) organisations are not equipped to bid for funding (e.g. lack of time or expertise in writing funding applications), unlike larger organisations. Yet, small VCFSE organisations often promote good health and wellbeing among underserved populations, and have shown that they can make a real difference within their communities. The report calls for Birmingham City Council and the West Midlands Combined Authorities – among other regional bodies – to issue calls for micro-funding to support health and wellbeing in the City, and commends the Birmingham and Solihull Integrated Care System for its innovative Fairer Futures Fund. The aims are to:

- Build on existing good practice among VCFSE organisations, and scale up existing projects that promote good health and wellbeing.
- Maximise VCFSE organisations' impact in their local communities, by providing them with the adequate resources to support local residents' health and wellbeing.
- Strengthen collaboration between the public and third sectors.

9 Involve voluntary, community, faith and social enterprise (VCFSE) organisations, and local residents in research. The aims are to:

- Be more representative and inclusive, as underserved communities are less likely to engage in research when it is not led by the VCFSE sector due to a lack of trust.
- Create a new research culture, that is based on collaboration and community engagement.
- Build capacity within the VCFSE and communities, by equipping them with the skills and resources necessary to work with academics and/or larger institutions, so they can together access new funding opportunities, break silos, and maximise their impact.

Health Inequalities in Birmingham

Barriers Encountered in Underserved Wards in East and West Birmingham

1. Introduction

Health inequalities are not new. Across the UK, different populations and individuals experience good and ill health unequally, and this inequality has persisted over time. Health inequalities are caused by the social and structural determinants of health. As health inequalities have been further exacerbated by COVID-19, renewed attention is now being paid to those determinants of health and how to mitigate their impact on future health.

Some communities are more likely to suffer from poor health than others, depending on their race/ethnicity, geographical location, socio-economic status, characteristics (including protected characteristics such as disability or sexual orientation), etc. For instance, race is an important factor to take into consideration when looking into health inequalities. There is significant intersectionality between high levels of deprivation and race/ethnicity, which is the result of racism (historic, institutional, and structural). During the COVID-19 pandemic, it was clear that minoritised ethnic groups[1] were disproportionately affected by the virus, and experienced higher mortality rates. But it was never about race or ethnicity as such. Instead, the pandemic highlighted *existing* fundamental health inequalities, which were influenced by socio-economic positions. As pointed out in the evidence Aston University presented to Parliament, the pandemic raised "deeper questions relating to the interactions between ethnicity, living conditions, occupation, ambient air quality, cardiovascular health, health literacy, area deprivation, relative economic disadvantage, and poverty." These factors are all intertwined and contribute to the health disparities observed within communities, emphasising the need for a comprehensive approach to address them, and the need to acknowledge that racism, in all its forms, is an important factor that contributes to health inequalities. Therefore, it is imperative that we adopt an intersectional approach to research and policy development in these areas, which takes into account the complex interplay.

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[1] We do not use the label BAME (Black, Asian and Minority Ethnic) because it is an imprecise "catch-all term, frequently used to group all ethnic minorities together", which fails to acknowledge the huge differences in health outcomes between different racialised/ethnic groups.

Racism can contribute to health inequalities in other ways, such as racist attitudes within the NHS. A 2022 research project, commissioned by the national civil rights organisation Black Equity Organisation, revealed that 65% of Black people had been discriminated against by healthcare professionals because of their race/ethnicity. The patients most likely to report a positive experience of GP services were from the Irish (88.0%) and White British (85.5%) ethnic groups, whereas the patients least likely to report a positive experience were from the Bangladeshi (72.6%), Pakistani (72.8%) and White Gypsy or Irish Traveller (72.9%) ethnic groups. Cultural biases and racial stereotypes from healthcare professionals can also contribute to health inequalities. These have been named as contributing factors when explaining why Black women are four times more likely to die in childbirth than white women. The 2022 BLACHIR report explains how a long history of discrimination, biases, poor experience, and poor outcomes have resulted in a lack of trust between underserved communities (and in their report, namely the Black African and Black Caribbean communities) and public sector organisations. Combined with difficulties encountered when trying to access GP surgeries, this can lead to poor engagement with healthcare professionals and contributes towards the explanation of why some minoritised ethnic groups are more likely to suffer from poor health. For example, we know that Black women are more likely to be diagnosed with late advanced breast cancer, when it is more difficult to treat.

Groups can also be discriminated against because of their religious identities. Research has also shown that Muslim communities in the UK are more likely to live in areas characterised by high levels of deprivation, and are more likely to report being in (very) poor health, compared to the population as a whole (MCB, 2015). Islamophobia has been identified as contributing to health inequalities, and healthcare services seem to be failing the Muslim communities as demonstrated by poor health outcomes and low Muslim participation in some key national screening programmes, such as the NHS bowel cancer-screening programme. Research on Muslim women's experiences in maternity services has shown how Muslim women often felt they either had to explain themselves when discussing their religious needs (such as fasting or needing to remain covered up), or that they were not being oppressed and in need of saving. Concerns around healthcare professionals' (negative) representations of Muslims and Islam often influence Muslim communities' ability to fully engage with healthcare services, many stating they would rather avoid medical help altogether. There are other examples of explicit discrimination manifesting in institutional practice, such as staff belittling Muslim women's concerns, referring to it as "Asian woman syndrome". Some hospitals have refused to share the baby's sex, assuming the baby would be aborted if it was a girl. Beyond individual interactions, the wider socio-political context in which the Muslim communities engage cannot be ignored as a contributing structural determinant of health. Not only are negative portrayals of Islam and Muslims everywhere, but policies such as the Prevent duty (which forms part of the Government's counter-terrorism strategy) have created a climate where Muslims are reluctant to engage with public bodies through fear of being considered a suspect. Islamophobia is a contributing factor to health inequalities as it damages trust and inspires disengagement with healthcare systems. As the National Aids Trust puts it, "before we even start to look at their experiences within the health system, being Muslim does not put you on an equal footing" (National Aids Trust, 2019).

Health inequalities are not only unfair, they are also avoidable. With this in mind, Aston University and Birmingham Community Healthcare NHS Foundation Trust (BCHC) partnered with Citizens UK and community-led organisations in some of the most deprived wards of East and West Birmingham to i) listen to local residents talk about the hyperlocal barriers they faced to be in good health, and ii) co-design hyperlocal solutions to start addressing some of the health challenges. This collaborative project aimed to capture the voices and lived experiences of communities who live and/or study in some of the most deprived wards of East and West Birmingham – wards that tend to be populated by individuals from minoritised racial/ethnic backgrounds, many of whom also identify as Muslims.

While Birmingham went through a period of economic growth and regeneration, there remains a high number of wards that are characterised by economic and social deprivation. In 2021, of the 639 neighbourhoods in Birmingham, while 42 were in the 20% least deprived in England, 350 remained among the 20% most deprived in England (ONS, 2012). "Over time this has led to people in […] Birmingham being left behind some other parts of the city in key areas including health, job prospects and earnings, creating significant inequalities which must now be addressed" (Birmingham City Council, 2020: 6). East and West Birmingham are two localities where levels of infant mortality and childhood obesity are higher than the city's average. The localities are also characterised by a higher number of children in care, and lower educational outcomes, compared to the city's average. Residents in East and West Birmingham are more at risk of loneliness, more likely to have lower resilience and poorer mental wellbeing, and more likely to die early. Households in East and West Birmingham are more likely to be overcrowded, and to face food poverty and fuel poverty – all of which contribute to residents experiencing poorer health outcomes (Birmingham Health Profile, 2019). People living in East and West Birmingham face barriers to accessing healthcare and social services, and healthcare professionals in the areas are struggling to meet the needs of the local population. A number of large-scale initiatives have been implemented in recent years to address these issues, including the development of the Healthy Living hubs, and the launch of Flourish (the West Birmingham Community Health Collaborative) in 2022. However, there is still much work to be done to ensure that everyone in East and West Birmingham has the opportunity to access high-quality healthcare and improve their health outcomes, as the data shared in this report shows.

Aston University, BCHC, Citizens UK, and several community-led organisations came together to co-design this project, shape its direction and objectives, collect and disseminate the data. All community-led organisations were located in deprived neighbourhoods in East and West Birmingham, and were member organisations of Citizens UK:

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The objectives of the project were to:

1. Listen to communities that have traditionally been underserved and capture their voices and lived experiences
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3. Disseminate findings with the wider health ecosystem to help improve public health services – at the hyperlocal level and within the broader ICS (Integrated Care System) footprint of Birmingham and Solihull
4. Co-produce solutions, pilot community-led projects, and assess the impact of micro-funding on local communities
5. Use the findings to co-design future research projects, with a view to enable change

By shedding light on the impact of the loss of local services (such as leisure centres or community centres), the data from this project shows that barriers to living healthy lives not only relate to wider social determinants, but structural ones too as access to local healthcare services was often impeded. For example, the current mental health crisis affecting children, young people and adults is reported as exacerbated in these communities by the removal or cancellation of local services, for example the closure of swimming pools or local support groups. Finally, the data also highlights the gender health gap, demonstrating that women are more likely to be the ones who are unsupported when services are inaccessible, and the ones who encounter multiple obstacles when seeking care for themselves and for dependents. The findings are presented in this report, alongside a series of recommendations.

We recommend that the data collected for this project is used to inform the further development of locally led initiatives aimed at improving health outcomes and reducing health inequalities in East and West Birmingham. Beyond the present report, the data and recommendations have been shared with public health and local authority teams, to help develop and implement more effective strategies and policies for tackling health inequalities in East and West Birmingham, and beyond.

2. Community partners

For this project, Aston University and Birmingham Community Healthcare NHS Foundation Trust (BCHC) teamed up with Citizens UK and community-led organisations to identify barriers that lead to poor health outcomes, and to co-create hyperlocal solutions to tackle health inequalities in underserved wards in East and West Birmingham. This project aligns with Aston University's civic mission, which is to work with local citizens and regional bodies to make a difference on issues that matter to them the most – therefore ensuring that Aston's research agenda is driven by the needs of local communities to co-produce effective solutions.

BCHC is also committed to work collectively to tackle health inequalities, enhance quality of life, and help improve health outcomes in Birmingham. The 'Community Connexions' project (funded by the CRN – Clinical Research Network, in partnership with Black Country Healthcare Foundation Trust and Aston University) is one of their flagship patient and public involvement and engagement (PPIE) programmes. 'Community Connexions' seeks to capture the lived experiences of local communities in Birmingham and the Black Country – Wolverhampton, Sandwell, Walsall and Dudley to adapt healthcare services to better meet local needs, and to inform future health research.

Citizens UK is a people-powered alliance, dedicated to challenging injustice and building stronger and sustainable communities. Their members are education, faith, community, and union organisations that enable local leaders to develop their voice and come together with the power and strategy to make real changes in their areas and beyond. Member organisations of Citizens UK Birmingham strive for social justice and many of them are located in deprived and underserved wards. The organisations that co-designed the project and took part in the listening events and sandpit event were located in Aston, Lozells, Nechells, and Newtown. The organisations that joined the project for the sandpit event were located in Handsworth and Shard End.

2.1. Aston ward

Aston ward is located in the inner-city, to the west of the city centre. This ward is one of the most populous in Birmingham, and is characterised by a population that is growing slowly (24,447 inhabitants in 2021 compared to 22,307 in 2011) (City Population, 2021). Its population is young (over 50.2% of the residents are under the age of 29) and is predominantly from Asian/Asian British backgrounds (74.7%). Black, African, Caribbean and Black British make 17.2% of the population. In 2021, 55.7% selected the UK as their country of birth. 78.8% of the population identified as Muslim, and 14.8% as Christian. In terms of health, 48.3% identified as being in very good health, which is in line with the city's average (47.6%) and the national average (48.4%). 14.1% of Aston residents identified as disabled (Birmingham Census, 2021), which is below the national average (a quarter of UK residents according to SCOPE, 2023).

Aston ward is among the 20% most deprived wards in the country (ONS, 2021), and has the 9th lowest average income out of the city's 69 wards. Resident employment rates in the ward are significantly below the city average. In 2021, 61.2% had never worked, and 27.3% had not worked in the last twelve months. 51.5% of Aston residents had no qualifications (Birmingham Census, 2021). In 2018, the percentage of households in Aston in which no one aged 16 or over had English as a main language was 25.8% (Birmingham City Council, 2018). This is important to take into consideration as it is known that people who have English as a second language, or who struggle to speak English in Britain are more likely to be in poor health.

In the Aston ward, the team worked with Saathi House, a non-profit organisation with a focused approach on educating and empowering women and supporting young people. The organisation provides support to women by setting up and running a range of classes and employing community workers to tackle the needs of local women and develop youth work. Saathi House offers a range of classes/activities such as walks, cycling and coffee mornings, as well as advice on changing to healthier food and alternative medicines. Additionally, they also provide out-of-school play and education activities over the summer holidays for young people, as well as a Homework Club. Service users are mainly of Bangladeshi, Pakistani, and Bengali origin.

2.2. Lozells ward

Lozells is located in the west of Birmingham, and is one the smallest wards in terms of population. Yet, its population is growing, with 12,119 residents in 2021. Its population is young (with over 51% of residents under the age of 29 years old), and is made up of 74.7% Asian/Asian British and 18.6% Black, African, Caribbean and Black British. In 2021, 57% selected the UK as their country of birth. 79% of the population identified as Muslim and 15.1% as Christian (City Population, 2021). In terms of health, 43.6% identified as being in very good health, which is less than the city's average (47.6%) and the national average (48.4%). 14.1% of Lozells residents identified as disabled (Birmingham Census, 2021).

Lozells is one of the most deprived wards in the city and has the 8th lowest average income out of the 69 wards in the city. It is also among the 20% most deprived wards in the country (ONS, 2021). While the ward is often associated with narratives around gang violence, and high crime rates (drugs, knife crime, and robberies), serious crime has declined by at least 30% in 2022.

Employment rates remain much lower than the city average. In 2021, 62.9% of the population had never worked, and 25.5% had not worked in the last twelve months. 50.4% of Lozells residents have no qualifications (Birmingham Census, 2021). In 2018, the percentage of households in Lozells in which no one aged 16 or over had English as a main language was 27.8%, which was significantly higher than the average for Birmingham (9.4%) and for England (5.2%) (Birmingham City Council, 2018).

In the Lozells ward, the team collaborated with Aspire and Succeed, a community organisation that delivers a range of projects and free services, such as youth and community work, community advice clinics, advocacy and after-school tuition. Service users tend to come from local low-income households, and are mainly of Yemeni, Somali, and South Asian background.

2.3. Nechells ward

Nechells is an inner-city ward, just west of the city centre. Its population is rapidly growing (16,145 in 2021, compared to 11,021 in 2011). The ward has a significantly younger age profile than the city as a whole, with 64.5% under the age of 29 (City Population, 2021). The population of Nechells is fairly diverse, with 41.8% identifying as Black, African, Caribbean and Black British; 29.3% as White; and 29% as Asian and Asian British. 59.1% of Nechells residents were born in the UK, 15.3% in Africa, 13.6% in the Middle East and Asia, and 8% from the European Union. In 2021, 47.2% of the population of Nechells identified as Muslim, 30.9% as Christian, and 21.9% as non-religious. In terms of health, 53.1% identified as being in very good health, which is above the city's average (47.6%) and the national average (48.4%). 13.8% of Nechells residents identified as disabled (Birmingham Census, 2021).

Nechells is amongst the city's most deprived wards and has the lowest average income out of the city's 69 wards. It is also among the 20% most deprived wards in the country (ONS, 2021). Resident employment rates are well below the city average and economically inactive residents (those that are not in work or seeking work) account for nearly half of the working age residents in the ward. In 2021, 45.1% had never worked, and 29% had not worked in the last 12 months. 27.1% have no qualifications (Birmingham Census, 2021). In 2018, the percentage of households in Nechells in which no one aged 16 or over had English as a main language was 16% (Birmingham City Council, 2018).

In the Nechells ward, the team worked with Aston students at Aston University. Serving the region and society is a crucial part and an integral arm of Aston University's beneficiary-led strategy. The student body consists of a highly diverse local community and friendly international community from over 120 countries. The majority of the students that attended the listening event were international students.

2.4. Newtown ward

Characterised by a rapidly growing population (16,290 residents in 2021, compared to 9,513 in 2011), Newtown is an inner-city ward located just to the west of the city centre. The ward has a younger age profile than the city (63.8% are under the age of 29) (City Population, 2021). It is a diverse ward, with 51.4% of the population identifying as Black, African, Caribbean, and Black British; 28.9% as Asian and Asian British; and 19.7% as White. 57.3% of Newtown residents were born in the UK, 17.7% in Africa, 11.5% in Asia/Middle East, and 7.7% from the European Union. In 2021, 50.7% of Newtown identified as Muslims, 34% as Christians, and 15.3% as having no religion. In terms of health, 53.7% identified as being in very good health, which is above the city's average (47.6%) and the national average (48.4%). 12.8% of Newtown residents identified as disabled (Birmingham Census, 2021), which is – once again – below the national average (SCOPE, 2023).

Newtown is one of the most deprived wards in the city, and is among the 20% most deprived wards in the country. Crime, gang violence, and poor housing conditions are common in the area – these have been exacerbated by funding cuts. Unemployment is also another issue, with 42.7% who have never worked, and 29.3% who have not worked in the last 12 months. 27.8% have no qualifications (Birmingham Census, 2021). In 2018, the percentage of households in Newtown in which no one aged 16 or over had English as a main language was 24.5% (Birmingham City Council, 2018).

In Newtown, the team collaborated with two organisations: i) Huda Masjid and Community Centre, and ii) the BLESST Centre. Huda Masjid and Community Centre is a Mosque and a community centre located within the St George's estate of the Newtown Ward. Most of their members are local families on low income, living in council housing within the estate. The centre provides a range of activities aimed at serving the local communities by meeting their religious, educational, social, and cultural needs. The centre focuses on advancing the education level of the communities they serve, and provide facilities for social welfare, recreation, and leisure with the objective of improving the conditions of life for all residents in the area. Service users are mostly from Somali heritage.

The BLESST Centre is an organisation dedicated to creating a safe and empowering environment for young people and families. Their aim focuses on self-development, learning, and transitional change for all by building positive relationships and working with communities, families, and schools as well as professional practitioners.
The BLESST Centre is a grassroots community with four directors, five Voluntary Specialist worker's and three youth and community leader organisers. They deliver a range of activities such as a youth therapeutic music programme ("Creative writing in the mic booth"), and mentoring schemes to support marginalised community students. Their service users are mostly Black young people.

2.5. Handsworth ward

Handsworth is an inner-city ward, located to the west of the city centre. The ward has a stable population with 11,820 residents in 2021 (compared to 10,960 in 2011). Handsworth's population is young, with 45.72% being under the age of 29 (City Population, 2021). 70% of the residents come from an Asian or Asian British Background, 20.3% identified as Black, African, Caribbean and Black British, and 9.7% as White. 55% of Handsworth residents were born in the UK, 29.5% in the Middle East and Asia, 5.9% in Africa, and 5.3% in the European Union. In 2021, 56.7% identified as Muslim, 24% as Christian, and 19.3% as Sikh (Birmingham Census, 2021). In terms of health, 45.8% identified as being in very good health, which is below the city's average (47.6%) and the national average (48.4%). 15.1% of Handsworth residents identified as disabled (Birmingham Census, 2021).

Handsworth is also characterised by high levels of deprivation. Resident employment rates in the ward are much lower than the city average. In 2021, 57.2% had never worked and 32% had not worked in the last twelve months. 49.9% hold no qualifications (Birmingham Census, 2021). In 2018, the percentage of households in Handsworth in which no one aged 16 or over had English as a main language was 21.2% (Birmingham City Council, 2018).

Bringing Hope joined the project in March 2022, when representatives attended the sandpit event. Bringing Hope is a charity based in Handsworth that works in prisons and the community with those involved in serious violence and crime. They provide one-to-one pastoral care, family therapy, group work, mentoring, and peer support with the aim to address the root issues of social exclusion and crime. The work of the charity is governed by a Christian ethos and work with people of all faiths.

2.6. Shard End ward

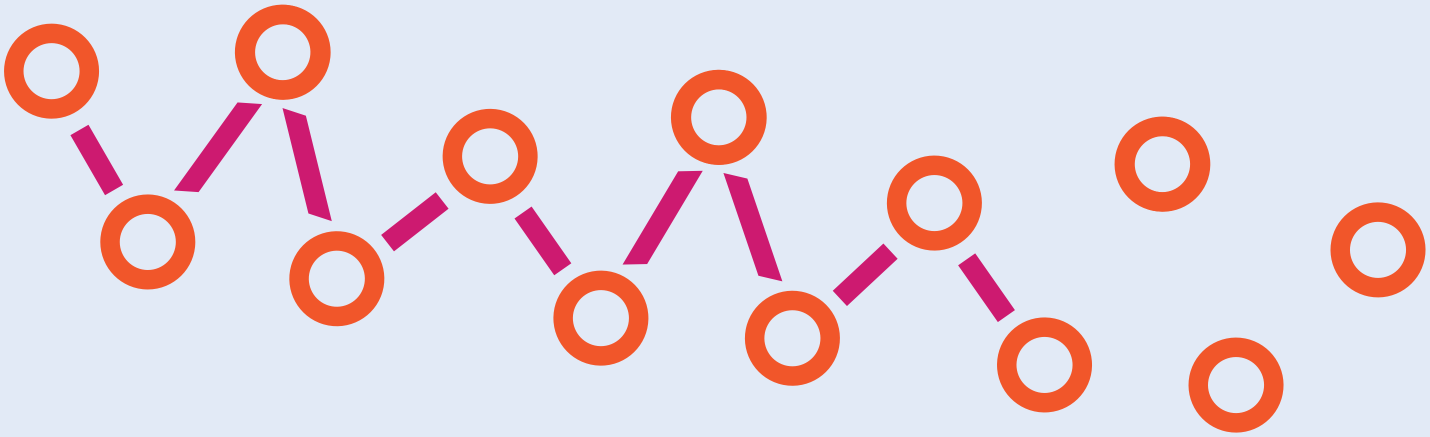
Shard End is an outer-city ward, located in East Birmingham. As stated in the East Birmingham Growth Strategy (2021: 15), "[c]ompared with many other parts of the city, people in East Birmingham have shorter lives and are far more likely to experience poor health. The number of people living with, or dying early from, long term health conditions like diabetes, respiratory problems and heart disease is much higher in East Birmingham than in other areas. Rates of mental health problems are also high, ranging from depression and anxiety through to schizophrenia and bipolar disorder."

Shard End has a population of 12,325 residents (City Population, 2021). Compared to other wards, Shard End is not characterised by a young population (with 40.9% under the age of 29) – its largest group is the 30-39 year-olds. 84.1% of the population identifies as White; 47.2% identify as Christian and 43.5% as non-religious. In terms of health, 42.6% identified as being in very good health, which is below the city's average (47.6%) and the national average (48.4%). Almost a quarter (23.2%) of Shard End residents identified as disabled (Birmingham Census, 2021), which is in line with the national average (SCOPE, 2023).

Shard End ward is one of the more deprived wards in the city and average income levels are below those for the city as a whole. In 2021, 34.9% had never worked and 54.7% had not worked in the last twelve months. 46% hold no qualifications (Birmingham Census, 2021). In 2018, the percentage of households in Shard End in which no one aged 16 or over had English as a main language was 1.1% (Birmingham City Council, 2018).

Two organisations with branches in Shard End joined the project in March 2022 by attending the sandpit event: i) Age Concern, and ii) Welcome Change CIC. Age Concern is a local charity committed to the communities in and surrounding Birmingham. Their focus in on meeting the needs and enriching the lives of older people and others in need. They deliver services and comprehensive support to over 17,000 unpaid Birmingham carers who look after a family member or friend who is elderly, frail, has an illness, disability, or addiction. They offer a range of services to promote wellbeing and independence. Services include day care centre and support, community hubs and cafes, financial advice, legal services, grant assistance, etc. Although Age Concern's offices are based in Sutton Vesey, they operate across the city. For this project, they focused on their hub located in Shard End.

Welcome Change CIC is part of the SIAS (Solihull Integrated Addiction Services) partnership, offering treatment and support services to individuals with drug and alcohol use that has become problematic, and to their families and friends. They provide safe and welcoming spaces in which people can access support, build skills and confidence, improve their health and wellbeing, and become actively engaged in society. They are underpinned by the value of enterprise to help address social inequalities and boost mental wellbeing. They also have a community garden which is open to the public, and where they held their funded project, Soil to Boil.



3. Engagement methods

3.1. The listening events

Aston University and Birmingham Community Healthcare NHS Foundation Trust (BCHC) worked with Citizens UK to reach out to community-led organisations located in underserved areas in East and West Birmingham, who provided support to local residents to help improve health and wellbeing, and who would be interested in co-designing the project. Four organisations accepted our invitation to work together:

- Aspire & Succeed (located in Lozells)
- BLESST Centre (located in Newtown)
- Huda Community Centre (located in Newtown)
- Saathi House (located in Aston)

An initial meeting was held to assess the best models of community engagement. It was suggested that hosting listening events with service users within their own premises, at a date and time that bests suited them and the participants, would be the best way to start the project. This methodology had previously been trialled by Citizens UK and Aston University[2] for the Eye Health project (funded by UKRI in 2019), and had proved successful. It was also felt that this was an engagement method with which most participants were familiar, and with which they would be most comfortable.

Prior to starting the listening events, the team obtained ethical approval from the School of Social Sciences and Humanities Ethics Committee at Aston University to conduct the project. Once ethical approval had been obtained, another meeting was arranged with all the partners to discuss the running of the events. The aim was to ensure that all groups would remember to seek informed consent from the participants prior to collecting data (and throughout the events), ask similar questions, and discuss effective ways to advertise the events. The meeting also provided a chance for partners to ask/answer any questions. It was agreed that Citizens UK would help facilitate discussions, as participants trusted them and felt comfortable with them – Aston University and BCHC partners were to take notes and support as needed during the day. Having Citizens UK involved in the project was crucial, as they had built trust with voluntary, community, faith, and social enterprise (VCFSE) organisations in underserved areas over the years, which meant that the community partners felt comfortable with the project.

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[2] In 2019, UKRI awarded Aston University led consortium funds (with Citizens UK and Aston Villa Foundation) to conduct the Eye Health project, which sought to deliver a programme of eye-health awareness lessons in classrooms, free vision and colour vision screening, followed by a more comprehensive eye test and free glasses to children who require them, using a fully operational custom-designed mobile eye care unit.

A series of five listening events were then held throughout February and March 2022 in Aston, Nechells, Newtown, and Lozells (four community-led events and one student event), during which culturally appropriate food and refreshments were always provided to thank participants for their time and contributions. Using venues that are often used by participants ensured that:

i) Participants knew where to find the event, and how to access the venue

ii) The venue was conveniently located for local residents, who did not have to rely on transport

iii) The timing of the session fitted well within the normal schedule of the community centre

iv) Participants felt comfortable in the space

At the beginning of each event, the project team ran an informal five-minute presentation explaining the project to participants, providing information about the partnership, and going over the aims of the listening events. The team also reviewed the participant information sheet, which had been circulated prior to the event via a Sway link. On three occasions many participants did not have English as a first language. In these cases, community interpreters were used to make sure that participants who spoke English as an additional language were able to hear the presentation in a language with which they were more comfortable. It also enabled participants to ask questions in their own language if they preferred.

Participants were then asked to sign a consent form (see Appendix 1). However, it was noted that in the future the team would seek to get informed consent orally, rather than written, and collectively, rather than individually (amendments that were accepted by the Ethics Committee). This was in response to participants explaining that there can be a mistrust of signing papers, due to potentially negative experiences with public authorities and administrative documents (e.g. asylum-seeking process). Furthermore, not all participants were able to read, and/or write, which can limit participation, and reproduce power imbalances and inequalities as they would have been excluded from the project.

Once the team obtained informed consent from the participants, small talking groups were created. Each group had a facilitator and note-taker. Community organisations and Citizens UK provided facilitators for every listening event. Colleagues from Aston University and BCHC also facilitated some of the discussions, where deemed appropriate, and often took on the role of note-takers. In three instances, facilitators also provided interpretation services. In small groups, the facilitators asked participants a series of questions related to health and care (see Appendix 2 for prompt questions), inviting participants to talk about health and obstacles to living a healthy life. At the end of each session, all participants regrouped together, and a representative from Citizens UK reported back on some of the conversations that had been shared in small groups. They then opened up the room for conversation, facilitating more of a discussion across groups and providing opportunities for comments and questions. Participants were then invited to enjoy the food and refreshments. Each session lasted on average two hours, some ending after 90 minutes, others going slightly over 120 minutes.

After each event, written data was collected and all notes from the note takers were shared with the project leads at Aston University and BCHC to collate and analyse – the main findings are presented in this report, which has been written in consultation with all community partners. The findings will be used for further publications, and will be disseminated in various formats (including infographics and videos) to a wide range of stakeholders in the region, including:

- Birmingham Community Healthcare NHS Foundation Trust
- The Mayor’s West Midlands Health of the Region Roundtable
- Birmingham and Solihull Integrated Care System (ICS) – through the Health Inequalities Board
- The Health and Wellbeing board (via Director of Public Health)
- Academics (to inform the health research agenda, and provide further evidence required to affect change)

In total, just under 100 participants took part in the listening events. The majority of participants were women (85%). Even though the events were open to all, the team found it difficult to reach a significant number of men. The team found that women were more likely to want to share their experiences of health and accessing healthcare services, especially when they were caring for dependents. In the future, attention needs to be paid to finding strategies to engaging more men.

Participants were mostly from minoritised ethnic groups, which reflected the local populations. Participants’ backgrounds included: South Asian heritage (44%), Somali heritage (26%), Black British (14%) and other minoritised backgrounds (16%). The number of people attending each event varied – with the smallest event attracting 6 participants, and the largest event attracting just over 30 participants. Flexibility was key to making the project work as partner organisations catered for different community groups.

After each event, facilitators sought immediate feedback from participants, which included positive comments such as: “privileged to be involved and speak to professionals”, “opportunity to hear view from community”, “sad and upsetting”, “feel a real expectation to act and have an impact”. It was clear from all the listening events that people appreciated having representatives of the NHS, Citizens UK and Aston University listen to their concerns and experiences. However, many also said that they felt they had been consulted too many times, without seeing any changes or progress being made. Comments were made that often people come and collect data, and never come back. Communities feel that they share the same concerns over and over again without seeing any improvement. More than once, towards the end of the sessions, the team was approached and asked to run follow-up health literacy events, to respond to some of the concerns raised during the listening events. While BCHC was able to organise some health literacy sessions, the team felt that listening to underserved voices was not enough, and that participants should play an active role in proposing and implementing solutions, which was the aim of the follow-up community sandpit event.

3.2. The community sandpit event

The project team was keen to ensure that after the listening events, there would be an opportunity to meet together to talk about the findings and possible ways forward. It was decided to host a one-day community sandpit event, building on an example of community engagement initiated by Vocal. The team chose to call the event 'community sandpit' – to reflect the co-constructed nature of the event. The 'sand' was the data that emerged from the five listening events, and now it was for community partners to come together in the 'sandpit' and decide what to build, and with what tools.

To be inclusive and promote networking opportunities, the community sandpit event was open to all community-led organisations in East and West Birmingham who worked to improve health and wellbeing in their localities. An invitation to attend the event was shared on social media and via the Birmingham Voluntary Service Council's (BVSC) newsletter. If interested in joining, community-led organisations were invited to submit an Expression of Interest. A total of nine organisations attended the community sandpit event. Community-led organisations that expressed interest in being involved in tackling health inequalities, and who were able to attend the event and join existing community partners were:

- Age Concern Birmingham (located in Shard End)
- Bringing Hope (located in Handsworth)
- Welcome Change CIC (located in Shard End)

While a representative from House of Play + Education (located in Acocks Green) also attended the community sandpit event, they chose not to submit any bid at the time. They were, however, able to forge new partnerships with other organisations present on the day.

The objectives of the sandpit event were to:

1. Reconvene together as a team, and share views
2. Involve new community partners that also strive to tackle health inequalities in underserved areas of East and West Birmingham
3. Share findings from the data collected, and provide opportunities for discussion/comments
4. Identify key priorities for East and West Birmingham to support local residents' health and wellbeing
5. Propose hyperlocal projects to help tackle health inequalities, for which a total of £6,390 was available

The agenda for the sandpit can be found in Appendix 3. The day started with a presentation and summary of the key findings that emerged from the five listening events and time for questions/comments. Community partners were then each given the opportunity to respond to the findings. This was then followed by breaking into smaller groups to discuss initial ideas in which to collaborate to propose solutions to tackle barriers that lead to poor health outcomes in their localities. Micro-funding (£6,390) was made available by Aston University and BCHC to work with community partners who proposed local and hyperlocal projects to tackle some of the issues that arose from the findings.

The sandpit event provided community partners the idea to co-design and propose solutions to help improve health outcomes. The afternoon session was effectively a writing workshop, during which community partners wrote their applications, with support from Aston University and BCHC. It is important to note that community partners were not asked to go away and write their proposals for micro-funding. This was done on-site, with support from Aston University and BCHC, to address the following issues:

- Community partners had expressed not having enough time to apply for funding – due to a lack of capacity (many organisations relied on volunteers)
- Community partners had expressed not always feeling confident writing funding application – due to a lack of practice, but also because experience of writing funding applications tends to be off-putting and daunting for small organisations that do not have bid writers (unlike larger organisations)
- Many bids and procurement systems can be really difficult for community organisations to access

The reasons why micro-grants were made available during the community sandpit event to make funding more inclusive and more accessible to smaller community organisations that can have an important impact on local residents' health and wellbeing. A total of nine project proposals were submitted, via forms that had been circulated on the day (see Appendix 4). Colleagues from Aston University and BCHC reviewed and evaluated the project proposals. In some cases, amendments were proposed (e.g. joining similar projects together). In one case, the team was able to support one project on health literacy without providing funding, as BCHC was able to provide healthcare professionals who would visit Saathi House to share tips about living healthy lives, and who would host a series of Q&A sessions. A total of five projects were funded – the details of which can be found in Section 5, and in Infographic 1.

4. Findings from the listening events

The data collected during the five listening events are presented in this section. These are the findings that were presented during the community sandpit event, and that are captured in two sets of infographics, which have been disseminated to a wide range of stakeholders (see Infographics 2 and 3). Although each community group talked about their own needs and concerns regarding access to healthcare and barriers to living healthy lives, common themes emerged across all listening events. While wider determinants affecting general health and wellbeing were indeed discussed, and raised concerns among participants, the data shows that austerity measures and a decade of underfunding the NHS and Local Authorities have taken a huge toll on underserved populations – many of whom are now unable to access healthcare services. The main issues that were raised included the difficulties encountered to secure an appointment with a GP, lengthy waits, and language barriers. Participants also shared issues encountered within primary and secondary care, such as concerns about the (lack of) quality of care, and descriptions of rude or hostile behaviour from some NHS staff towards patients. The findings also show that in underserved settings, women tend to be the ones seeking to access healthcare services (often on behalf of dependents), and the ones who therefore encounter barriers more frequently.

4.1. Barriers encountered to access NHS services

4.1.1. GP access

Across all groups, participants shared how they encountered great difficulties in accessing their GP. Lengthy wait times, limited appointments, or not being able to get through on the telephone waiting system to speak to a receptionist (and thus a GP) were amongst the main issues reported. These were not one-off events, but the norm. In one group, participants explained they found it nearly impossible to see a GP after their local GP surgery closed down. Although they have now registered with another local medical centre, it seemed it could not cope with the increase in patients. As a result, while on paper patients have been assigned a GP, some of them have found it nearly impossible to secure appointments. As a result, some resulted to self-medicating, others waited longer to be seen, and ended up going to A&E. International students said it took them up to three months to get registered with a GP when they arrived in Birmingham, leaving them without access to primary care in the interim. Many participants found themselves in limbo – referred from service to service, without getting treated.

Participants shared dissatisfaction with booking systems. Whether participants telephoned their GP surgery or went in person to speak to a receptionist, they all encountered long queues and long wait times. All participants encountered difficulties getting through to a receptionist. On some occasions, poor communication about opening hours meant that participants waited in long phone queues only to learn that the surgery was in fact closed. Examples included automated hold lines not being set to notify patients that the GP surgery was currently closed, and where to go for medical assistance in the meantime.

Some participants (mostly mothers) reported having to queue outside their GP surgery as early as 7:00am in the hope to secure an appointment with their GP, and having to walk away, unsuccessful, in order to do the school run. Women seemed to be disproportionately carrying the burden and emotional load of trying to manage getting an appointment with childcare responsibilities – a gendered trend seen throughout the data collected for this project. Other participants shared similar examples of being left desperately queuing outside their GP surgeries or waiting hours on the phone in a bid to get an appointment, which interfered with responsibilities such as getting to work on time. In fact, some participants even reported booking time off work in an effort to get an appointment with their GP.

Some participants reported that when they were 'lucky' enough to get an appointment with a GP, access issues continued. One of the main barriers was around telephone consultations. All participants felt that most appointment policies in GP practices had not been updated since restrictions were imposed on patients during the COVID-19 pandemic (e.g. GP surgeries making people queue outside the surgery instead of using waiting rooms, and GP surgeries mainly offering telephone consultations). Participants explained that they found telephone consultations difficult especially when English was an additional language. A large number of female participants reported that they did not find telephone consultations effective as they were not able to show their GP what was wrong with them and/or their dependent, and that as a result they often could not get a diagnosis. For example, one mother who had successfully managed to speak to her GP on several occasions about concerns regarding her child's health had been consistently sent away without any diagnosis or treatment for her child. Once in Germany visiting relatives, she took her child to a GP who diagnosed her with a food allergy. Another participant explained that after having been dismissed by their GP, they were eventually diagnosed with kidney stones and were able to receive treatment in A&E.

Participants reported that they felt that GPs spoke too quickly on the phone, and/or were often unwilling to repeat the advice, even when requested to do so. Participants shared examples of telephone consultation ending automatically after ten minutes, leaving them at times unable to ask follow-up questions or seek clarification. There were reports of telephone consultations being automatically cut off mid-sentence after 10 minutes regardless of whether the GP or patient were still speaking. These time restrictions exacerbated access issues for participants for whom English was an additional language. In several instances, this left participants confused about what they should do next. Participants felt the time constraint would be less of an issue if they had continuity of care (i.e. the same family doctor who knew them and knew their medical history, but also whose voice and accent would sound familiar and be easier to understand).

Participants also shared their thoughts about phone follow-ups – as GPs often ended the consultation by sending a link to patients so they could provide more information about their condition and/or upload a photo. Many felt that the forms they were being sent asked for the same information multiple times, or asked to reiterate what they had told the GP. Others stated that the forms were not clear enough, and that translation was not available to those whose first language was not English. Many of the attendees also reported not being able to access digital follow-up services due to a lack of access to a computer and/or reliable broadband. In many cases, participants encountered several issues at once. In several instances, leaders from locally trusted community organisations had to step in to support patients when filling out online forms, with patients having to reveal private information about themselves in order to seek medical assistance. Those community organisations are usually not funded, with members volunteering their services to the local community. Participants felt that this support ought to be made available by the NHS, or at least in partnership with the NHS, and that GP surgeries needed more staff, not forms. All called for better funding from government.

Across all of the groups, it was commonly reported that when people could not get support from their local GPs, they ended up going to the local walk-in centre (when available) or to A&E. Attending A&E was a common decision, though not taken lightly. Participants expressed concerns about contributing to long queues in A&E, and worried about being stuck in A&E for hours themselves – an issue for many women who also had caring responsibilities. While they considered A&E their last resort, too often they felt forced to go there as they were either not able to see their GP, or were not able to get a diagnosis from their GP. Some participants, however, shared instances when healthcare professionals greeted them with comments such as “you shouldn’t be here”, “why are you wasting our time?”, making patients feel distraught, and at a loss as to what to do and where to go next.

For example, one participant explained that she tried to book an appointment for her son, who was very ill and throwing up. The GP surgery said the GP could not see him as there were no appointments left. They went to A&E, where they were told they were too busy, and were referred to the Children’s Hospital. Another participant had a child who badly damaged their knee in the school playground and who had been sent home as a result. Once again, the GP surgery told them there were no GPs available, and advised them to go to the hospital. When the mother and child arrived at the hospital, the staff shouted at them for wasting their time and explained they should have gone to their GP. Finally, another participant, whose child fainted in school and was sent home, called her GP but was not able to secure an appointment. The GP surgery sent them to the local walk-in centre, which was full and referred them back to their GP surgery.

Barriers to accessing primary care services led some participants to opt for alternative healthcare, or, in rarer cases, to private healthcare providers. However, most of our participants were not able to afford private care (and several explained that they wanted to be treated by the NHS anyway – not private healthcare professionals). Many participants ended up relying on online sources to seek treatment. Student participants reported using alternative services such as Babylon Health. While Babylon Health partners with the NHS to offer a digital-first model of care, most of the websites and social media the students consulted were not supported by the NHS.

As a result of the difficulties many faced to access primary care, many participants explained they no longer turned to their GP as their first point of contact for healthcare needs/concerns, instead seeking advice from friends, family, social media, and alternative medicine. Many participants relied on pharmacists, and expressed that they were happier with the service and guidance provided by community pharmacies. The issue at this stage, however, is that pharmacists are not necessarily equipped to support patients, especially as their role focuses on dispensing medication. This is likely to change, though as the new NHS England Primary Care Recovery plan talks about extending the role of pharmacy, with an investment of up to £645 million and the launch of Pharmacy First to supply prescription-only medicines for seven common conditions. Expanding the role of community pharmacists and other pharmacy staff aligns with recent research findings too. One of the barriers to take into consideration here is that many participants found it expensive to rely on community pharmacies and on over-the-counter medicines, and most participants needed to speak to a GP to be eligible for free prescriptions and free medicines.

Not being able to access GP services resulted in a lack of trust. Many participants felt that they were not considered “important” enough for GPs or for “those in charge”. This raised questions about whether they would be looked after properly, if they ever made it past the receptionist. The issues raised about barriers to accessing GP services demonstrate how a decade of underfunding is affecting access to primary care, and is eroding trust in the NHS. These findings corroborate with data collected through the national GP Patient Survey: Worst GP practices in Birmingham - as judged by patients - Birmingham Live (birminghammail.co.uk).

4.1.2. Referrals and (dis)integrated care

Across all the groups, access to GPs was not only viewed as a necessity in order to get treatment, but also to get access to additional healthcare services. Participants felt that if they needed support from any NHS healthcare services, they first needed to meet with their GP and get a formal referral to a specialised service. Not being able to access GPs meant not being able to access other healthcare services, such as physiotherapists. Very few participants seemed aware that some services were available to them without any GP referral, which highlighted the lack of effective communication with patients. Similarly, very few participants seemed to be aware of the different services available, and what can be covered by the NHS. One participant found out through attending one of the listening events that a fellow participant was getting acupuncture and homeopathy for a medical condition, which were covered by the NHS. Sharing similar ailments, they made a note to ask their GP for a referral too. Participants expressed the need for better awareness and information on what services are available within the NHS and how they can be accessed.

" Signpost people, calmly, with a smile."

The Patient Advice and Liaison Service (PALS) service was another example of service mentioned during the listening events (by an NHS member of staff) – not many people knew about it, and some participants were keen to tap into this service as soon as possible. Additionally, many students were unaware that depending on their circumstances they might be able to access services such as dental care and eye care for free.

Lack of communication between different NHS services also contributed to access issues. Participants felt that too often different NHS trusts/services did not speak to each other. Not only did they have no continuity of care with their GP surgery, but once they attended a referral appointment they often felt as if they had to start all over again. Participants across all groups shared examples of trying to access referral appointments, with no success. They explained how this was often the result of information-sharing breaking down, and the referral getting lost between primary and secondary services. It was brought up more than once that participants felt they had different people all telling them different things and it seemed to be adding to the delay in receiving the treatment and support required. One participant remarked: "when there was no Internet and less information, the NHS was more effective". There was a clear sense of the NHS having become 'disjointed'.

For example, one participant was referred to hospital for a blood test by their GP, when they arrived at the hospital, no paperwork had been received; when the hospital called the GP practice, they were told the GP was out and the patient was sent home and had to reschedule their appointment with the GP and start all over again. This led to participants feeling frustrated, especially given the difficulties encountered in the first instance to access primary healthcare. Another example included one woman and her children – all of whom have had asthma since moving to Birmingham – going to A&E several times, after encountering severe respiratory problems. They were supposed to have a follow-up appointment with their GP, but the GP never contacted them. When the mother called the GP practice, she was not able to secure an appointment. Another participant shared a story about having blood tests, and then being told that the results got lost between the different services, and needing to have blood taken again.

Several participants shared similar experiences. Some felt that they were being passed around between GPs, hospitals, and other services. This caused a real frustration amongst participants, and exacerbated their lack of trust in the NHS.
In a few limited cases, people reported this had led them to go private with their healthcare, while recognising that not everyone can afford this option and expressing a preference for public healthcare. Most participants found that accessing healthcare had become not only time-consuming but also energy-consuming.

Once a referral appointment was finally secured, participants explained that they often had to wait a long time to be seen, with participants reporting lengthy waits taking several weeks or even months for an appointment. One woman explained how she had been referred to a physiotherapist after having been in a car accident. Nine months later, she was still waiting for her appointment, finding it more and more difficult to cope with the pain. Some also explained that once the day of the appointment finally happened, they found themselves stuck in waiting rooms in hospitals for long periods of time. Some participants shared experiences of having to wait up to nine hours. They emphasised this meant many could not stay long enough to actually be seen, and had to walk away especially if they had caring responsibilities. In several instances, patients were left waiting without access to food and/or refreshments. Specific services that were repeatedly mentioned were physiotherapy, maternity, and paediatric care.

4.1.3. Maternity and paediatric health

Participants across four locations raised issues related to maternity care (including antenatal and post-natal care) and infants' health (including health visiting services). During pregnancy, while mothers-to-be found it possible to have access to scheduled antenatal appointments, they found it more difficult to access support when they encountered issues such as reduced movements. A lot of it tended to be because of feeling like a burden on the NHS, which was often exacerbated by the long queuing times, and sometimes by attitudes of the staff (as described in further detail in 4.2 below). In hospital issues persisted, and across the data there were several experiences of issues with procedures, scans, and epidurals. One participant recalled having issues with a cannula being put into her arm instead of her hand and bleeding extensively, feeling like she was going to die. Another participant shared a traumatic experience with the maternity services where her baby died after she had preeclampsia that she felt was due to poor clinical care and a missed scan due to COVID-19.

Once the baby was born, several participants described having difficulty accessing health visitors, despite making repeated calls. Some of these concerns had to do with COVID-19 restrictions that had not been lifted. This meant that at the time of the research, many new mothers were not able to have face-to-face appointments with a health visitor. Once again, participants talked about the importance of having face-to-face appointments, and the need for babies to be seen rather than be described over a phone consultation. Many participants had never met their health visitors, and found that as a result they were less likely to be build a rapport, and as a result felt as if health visitors seemed less receptive to mothers' concerns. Participants described the health visitor experience as dehumanising. Several participants, who had had a baby before and after COVID-19 attested to the differences in care and support, explaining that they now felt that they did not receive the adequate follow-up visits anymore. In some wards, such as Aston and Lozells, it was reported that not all services provided by health visitors were available. For example, they reported there being no local weigh-in clinic for babies.

> *"One children centre for one district: it's not enough! One specialist Health Visiting team per district: it's not enough! The districts are too big. We need more centres, but we also need reassurance that they will stay. There's always a fear that things will get merged or will get pulled out again."*

The closure of local children's centres were cited as a huge barrier to the maintenance of babies' and children's health. New mothers found it particularly stressful, especially if they had questions about their baby's health, as there was nowhere to go and no one to ask for help.

> *"Children centres: why are they almost gone? This is a massive issue because what happens between the ages 0-5 matters! And it was about parents getting information or support or got to see what others were doing... Stay and play sessions were gold dust. It's about knowledge. Most don't know where to find that anymore. Where are the dads' groups?"*

There was a general feeling that the women wanted to get support from healthcare professionals, for themselves and their children, but that they could not find it. Concerns over support for children and young people continued beyond the early years. As many local children's centres have closed down, participants have explained that this means that children and young people are growing up without accessing NHS services regularly, alienating them further from the NHS. They are not growing up with healthcare professionals as part of their community or part of their lives. In participants' views, this absence will further exacerbate issues related to trust, and will likely lead to even less engagement with health services in the future. Participants not only talked about the need to have healthcare professionals integrated in their community settings and as part of their lives, but also talked about the need to see more healthcare professionals who look like them, and who understand their backgrounds. Young people fed back that there is huge distrust in the NHS within the Black community, and that this distrust runs across ethnicity and generations in their communities, making them unlikely to access healthcare services regularly. These findings echo those from the 2022 BLACHIR report, which states that "[a] long history of discrimination, biases, poor experience and poor outcomes has destroyed trust in statutory services" (p. 9).

Participants stated that they wanted more health education for children and young people, more spaces that are available in their communities to support children and young people with mental health, and provide them with greater awareness about the different services that are available to them, and where to access information on common issues such as drug awareness, dealing with trauma, etc. Across most groups, participants felt there was less support and fewer activities/groups available since COVID-19 for everyone, but particularly so for children and young people. Participants felt that COVID-19 had been used as an excuse to close down certain services and not re-open them, and to make services less accessible.

Support services were described as being “messed up” by the closures that occurred during the pandemic. For example, participants in Aston reported that their local health centre closed down during the pandemic, meaning that they now had to go to another ward (Newtown) to access services, making it difficult for many. Because of these pandemic-related barriers to access, participants described feeling isolated and encountering enhanced levels of stress and anxiety. This was acutely felt for participants with children, who saw higher levels of mental health and wellbeing issues in their children, which they attributed to the lockdowns restricting access to services. As a result of both a lack of services pre-pandemic and then a further restriction of services during the lockdowns, participants felt that everyone but especially children and young people were now being left behind, often isolated, and lacking necessary skills to do well at school and in society.

4.2. Barriers encountered within NHS services

4.2.1. Language and cultural barriers

In four out of the five groups with whom we worked, it was reported that language was still a considerable barrier to effective communication and to navigating the health system, leading to reduced quality of care. There was a general consensus among participants that better interpreting services needed to be offered. For example, one participant shared that she had been matched with a Punjabi interpreter, instead of Urdu – her language. As a result, she was only able to understand a limited amount of what her GP was saying. She was also left worrying that her GP may not have understood her if her interpreter did not speak Urdu. This, once again, exacerbated the lack of trust in the NHS. Similar experiences were particularly common for patients who spoke dialects of common languages. People who requested interpreters upon appointments shared that it often took too long to get them, which resulted in the consultation/treatment being delayed. While most of the time patients were left waiting whilst their GP surgery sought linguistic support, in some instances it led to appointments being cancelled, postponed, or even “lost” in the system. One participant explained that her appointment had been cancelled twice and only on the third appointment was she matched with an appropriate interpreter. This is contrary to NHS guidance that states that “patients requiring an interpreter should not be disadvantaged in terms of the timeliness of their access.” This experience made her feel very uncomfortable, and deflated with the service as a whole. Following her experience with the NHS, she explained that she felt “it [wa]s better to be home than be seen”.

During and since the COVID-19 pandemic, visitors have been restricted in accompanying patients. Most services do not allow patients to attend appointments accompanied. Several participants for whom English is an additional language stressed that this made their experiences far more difficult. They explained that they felt more comfortable when they were able to attend appointments with a member of their family to help with translation and interpreting, especially when it takes too long to arrange for an NHS interpreter. However, younger participants (including international students) shared concerns about patients using family members as interpreters. They were concerned they would make mistakes, which could have important consequences for their relatives' health and wellbeing. It is for this reason (among others), that the NHS has previously stated children should not be used as interpreters, and that family members are also strongly discouraged from acting in this role. The problem arose for participants when they or the patient were left with no other alternatives. Though most of our participants spoke fluent English, they cared for those who did not, and reported that those groups were often afraid to access healthcare and seek medical assistance because of their lack of linguistic skills. This leaves some community members without access to healthcare, making them particularly vulnerable.

Language was not the only barrier to care. Some participants found that the lack of cultural competence displayed by some healthcare professionals made it more difficult to access NHS services. Student participants expressed concerns about bias in datasets – in some cases, they reported being told that treatments were not suitable for some minoritised ethnic groups.

Many Muslim women shared that smiling was a religious custom that was part of their faith (Sunnah), and that small acts of kindness such as smiling could significantly add to their overall experience. However, as discussed below, healthcare professionals did not always greet patients with a smile, which made them feel less comfortable.

One participant explained how she was forbidden from bringing in food to hospital which the patient was used to eating, and the only options provided were not allowed by her faith. Overall, there was a feeling of a lack of cultural competence in participants experiences with the NHS.

4.2.2. Attitudes and behaviour of staff

Participants all acknowledged that they had met outstanding NHS staff throughout their lives, and were grateful for the care and services provided. However, poor staff attitudes and unfriendly behaviours had also been demonstrated by staff across multiple services and on a number of occasions. While many participants were cognisant and understanding of the fact that NHS staff are under-resourced and have become extremely busy, and that the system is overwhelmed, they still expressed the need to be treated with decency and respect, in the same way as NHS staff expect to be treated by patients:

> *"The staff looks tired, and angry."*

“We know they are busy; we understand they are busy; but they can still smile and treat us with respect.”

Many participants shared examples where they felt unwelcomed or felt as if they had been considered a ‘burden’. Some participants explained that after going through all the obstacles they faced to get access to their GP surgery, it felt particularly underwhelming, and at times aggressive, if the staff showed poor manners. Several participants explained how receptionists had been rude to them, on several occasions, making them wary of contacting their local GP surgery in the future.

There were several accounts in which receptionists talked loudly to patients, assuming they could not understand English. Such experiences made patients feel humiliated as others in the waiting room could hear about their conditions/ issues. On occasions, some patients unconsciously raised their voices to match the volume of their interlocutor, which was in turn interpreted as being rude. On one occasion a patient was escorted out by security, leaving her to feel extremely embarrassed and upset. On these occasions, participants felt that racism played a part in how they were being perceived and cared for.

Some participants said they were made to feel unwelcome both through verbal and non-verbal communication. Examples included subtle rude behaviour – such as indifferent tone of voice, poor body language cues and facial expressions, avoiding eye contact – as well as more direct rudeness – such as sighing, rolling eyes, or using impolite language. One participant mentioned she felt in pain after having had a caesarean. She therefore pressed the hospital button to call a nurse, but nobody attended to her. As she called in pain, she overheard the staff nurse say, “she needs to shut up”.

Several women described being worried about seeing midwives during their pregnancies, not just because of language barriers, but because many shared experiences of being told off by midwives for wasting their time. Many described trying to avoid the “condescending looks” midwives give them when they asked questions about pain or reduced movements. In hospital, issues persisted. This led pregnant women to avoid seeking medical assistance when they had reduced movements.

Some participants talked about the lack of cultural sensitivity. For examples, one participant explained that was sent to a male nurse and not offered a chaperone or the option to have a female nurse, which would have been more culturally appropriate for the patient. Since then, she has asked about the complaint procedure, but has not been given a response yet.

Most participants were not aware of how to complain about poor behaviours, but even when they did, they explained that they chose not to complain, for fear of being further mistreated in the future or encountering more difficulties to access healthcare services. These fears echo findings that people from minoritised ethnic backgrounds, including healthcare professionals themselves, do not feel comfortable speaking up against poor practice in healthcare environments. A few people also mentioned that clinicians need to build confidence with their patients as they felt the quality of the NHS and its services has declined, with many feeling it has become a service that prioritises quantity over quality.

4.2.3. Lack of trust in quality of care

The data so far shows that participants have found it difficult to feel "looked after" or "cared for", which often left them not trusting healthcare services. These findings echo those found in the 2022 BLACHIR report and demonstrate that trust is not only lacking "between the Black African and Black Caribbean communities and public sector organisations" (p. 9), but between minoritised communities (including minoritised ethnic and racial groups) and public sector organisations.

Unfortunately, participants often shared a feeling of not being heard, of not receiving adequate support, of not being taken seriously when talking about serious health issues, or of not mattering to healthcare professionals. This often exacerbated mistrust with the NHS and its services. Seeing a new GP at each visit rather than a family GP, who knew them and knew their family history, added further distancing between the patients and the NHS:

> *"We used to have a relationship with our family GP who used to know us and our family - this was the best care"*

> *"Why can't we have family GPs who know us, know our history so we don't have to start all over again at each appointment so we can build a trusting relationship?"*

Participants from minoritised ethnic backgrounds also explained that they wanted to see GPs and other NHS staff that "look like [them]" and who could relate to them. Tackling these issues were seen as necessary to (re)build a trusting relationship between patients and doctors.

In the meantime, most participants talked about how they were “losing faith in the NHS”. Participants were keen to explain that this was particularly true as of the last 5-10 years. They shared examples of feeling cared for and well looked after in the past. It was emphasised that the NHS and GP surgeries used to be good but in recent years they have noticed a real deterioration and the huge impact that funding cuts have had.

> *“People were fantastic fifty years ago. My mother when she arrived fifty years ago, although she was new to this country she loved the NHS, she absolutely loved the NHS. Now she’s petrified.”*

While participants acknowledged that the budget cuts were tough on NHS staff, it led them to question the quality of care as a result:

> *“There are issues with the NHS: it’s become quantity over quality. […] We are appalled to see how NHS staff is treated. Nurses are putting their lives at risk! The government doesn’t care about them. It doesn’t care about public health and mental wellbeing. The NHS staff care but don’t have the capacity to do anything. See the NHS march! Boris Johnson [then Prime Minister], if he gets unwell, he goes to the best of the best – we don’t have the best of the best on our doorstep.”*

In some cases, it was felt COVID-19 had been used as an excuse to cut down on services provided. Participants viewed budget cuts and the underfunding of the NHS as the reasons behind the deterioration of services and quality of care.

The overall feeling in all listening events was that healthcare professionals were not able to take time to listen to patients anymore, which they felt resulted in them jumping to conclusions, and in patients being misdiagnosed. In many instances, this led to patients having to go back to the surgery later on. For example, one participant called her GP as she had a high temperature for a few days. After a phone consultation she was told by her GP that it was likely to be COVID-19, and there was nothing that they could do. The patient wondered on what basis her diagnosis was made, given that the doctor had not seen her. Later on, it transpired that her fever was due to having contracted an infection that was not COVID-19, and for which she needed antibiotics. Many other participants shared similar stories.

Patients reported seeing GPs use computers and consulting databases when describing their symptoms. With no further explanations, some patients assumed that the doctors were consulting Google – or other general search engines – to diagnose them. Related to issues of trust outlined above, participants then questioned GP's knowledge and professionalism, and wondered if they could use Google themselves instead of seeing a GP in the future. During the health listening events, an NHS member of staff from BCHC was able to explain how some systems are commonly used by GPs, and that these are not similar to search engines, and that seeing a GP use a computer to enter symptoms in should not necessarily be indicative of the GP's diagnostic abilities. Participants really appreciated having their concerns heard and being offered clarification by an NHS member of staff, and explained how rare occasions to do so occurred. The lack of communication (often due to lack of time or lack of interpreting services) means that the gap between patients and healthcare professionals is widening.

Overall, participants described losing trust and confidence in the NHS. Many expressed feeling uncomfortable when trying to access healthcare. Some went as far as saying that they were "scared". A participant explained that she was in a car accident, with her mother-in-law on the passenger seat. While both got taken to hospital by ambulance, it took nine hours for the driver to be seen, despite losing blood. She lost so much blood from waiting that she ended up needing a blood transfusion. Her mother-in-law waited seven hours to be seen. This was an elderly woman who could not speak English. She was denied support from her daughter-in-law (the driver) despite already being in the hospital with her. She was also denied support from her son who offered to visit – and was left with no interpretation services. This led to her family worrying for her as she was diabetic, and no one knew that she needed feeding. The experience has left everyone traumatised, especially the mother-in-law who now refuses to go to the GP or take medication, and who is also refusing to go to her diabetic review.

Many other participants resorted to seeking medical help from friends and family. One participant described seeking dietary advice from his cousins, and not asking healthcare professionals. A youth worker explained how young people felt alienated from the NHS – their presence in the community having shrunk in the last decade with the closure of several programmes and some children centres. As a result, they witnessed children and young people seeking medical advice from peers and from social media instead of healthcare professionals.

> *"Less was more. There were less options, and no Internet. Now it's worse because we have so many different people telling us different things. It's even worse with our youth."*

Other participants also shared their preferences to using alternative medicine in the hope to avoid the NHS or avoid NHS prescriptions. One participant reported resorting to a Chinese herbal shop. Some participants explained that because they felt the NHS did not care about them, then they could not trust them: “Is the GP here for us, our wellbeing? Or for the big pharma and line up their pockets?” Young people in our project were generally doubtful of some of the ingredients in some medicines and many stated they were more interested in natural remedies and would appreciate advice rather than being told to take pills. The lack of trust is costly to participants’ health, as in several cases this translated into reticence to accept treatment, for example not wanting to get vaccinated against COVID-19.

Participants felt trust could be increased if they received higher quality of care, and the NHS took a more holistic approach to health. Some participants shared examples of being prescribed drugs when experiencing poor mental health, rather than being offered support and counselling, which they would have preferred. A mother who had lost a child explained how it would have been better for her to find a support network to help her grieve and accept her loss, rather than solely being prescribed drugs to deal with depression. Other participants explained that they would like to be told about alternative remedies, not necessarily to use instead of Western medicine, but alongside it. Some participants explained that they would find it empowering to be given more information and more options: “We need to be made aware of the consequences of certain choices. We would like to be told: ‘here are your choices, route A, and the consequences might be…, and route B, and the consequences might be…’ instead of ‘here’s your pill!’”

4.3. Mental health and children and young people

Poor mental health came up in every single listening event. Most participants viewed it as a key priority that needed to be taken seriously and tackled collectively. Parents especially felt helpless as they did not know how to support children and young people who were struggling with poor mental health, a health crisis which has been exacerbated by COVID-19. Isolation, feeling anxious and/or depressed were often cited as issues with which children and young people were dealing. Some parents explained that they did not feel equipped to support children and young people struggling with mental health, that referrals took too long (some were on waiting lists for several years), and appointments were regularly cancelled. Some young adults also explained that they found it more difficult to seek support from family, especially if they went through lockdowns together – isolation having brought up arguments as everyone was cooped up together.

The impact of bullying – which is increasing at school and online – on mental health was also brought up by participants. Although it is known that children from minoritised ethnic backgrounds are more likely to be bullied than their Caucasian peers, participants felt that local schools were not equipped to deal with bullying effectively. Parents shared examples where bullying led to mental health issues for their children. While it is known that children who have been bullied are more likely to suffer from depression, parents did not feel that schools, the government, or the NHS were taking bullying – and its impact on children and their health – seriously. Many parents voiced concerns that verbal abuse was common in schools, which then escalated when the person being abused challenged their abuser and then got in trouble for doing so. This then led to simmering tensions and issues being 'resolved' out of school, often with violence involved. Parents thus felt that schools should let parents be involved to help get to the root causes, since schools did not seem equipped to tackle bullying effectively. However, they also acknowledged that they themselves did not feel equipped to efficiently support children's and young people's mental health and would welcome further support. A parent shared calling a youth helpline to seek guidance to support her daughter who is suffering from depression and anxiety but stated she would have welcomed support from the NHS rather than relying on online charities.

Although the listening events took place as pandemic restrictions had lifted in England, many student participants still felt very concerned about COVID-19 and reported feeling uncomfortable touching surfaces, with many preferring to continue wearing a mask. Students expressed discontent with most services remaining online and not being able to meet other people much, factors which have added to their stress, and affected their mental health negatively. Students felt they had been affected physically by putting weight on. Many said they still felt isolated, and emotionally traumatised, and some even stated that they were depressed. Overall, students said that disruptions caused by the pandemic have taken a toll on their overall health and wellbeing. They explained they found it difficult to re-establish a routine, even years later, which they felt resulted in lower grades.

The data on children and young people came from adults who cared for children and young people. This report calls for a more systematic approach to directly include the voices of children and young people, rather than relying on adult accounts. This is especially important in Birmingham, which is the youngest city in Europe, with nearly 40% of the population aged 25 or under.

4.4. The impact of the local area

4.4.1. Importance and role of community centres

Across all the events, the importance that voluntary, community, faith, and social enterprise organisations (VCFSE) played to support good health and wellbeing was evident. VCFSEs such as community centres also seemed to be very effective at reaching out to community groups who have traditionally been underserved. Most of the centres ran some form of community advice sessions supporting their community with issues such as communicating effectively with their GP, interacting with healthcare professionals, findings ways to overcome language barriers, supporting children's education, and providing extracurricular activities that aimed at supporting health and wellbeing, providing financial advice, etc. The support provided by VCFSE organisations to their members and families went beyond the physical space of their centres/hubs. As such, local VCFSE organisations were seen to provide a more holistic service than the NHS. Community members also felt that they were in familiar – and therefore safe – hands. They also found it less intimidating to speak to people from their local areas, and from the same background.

Local initiatives and support groups were highly valued by all participants, regardless of their background and age. However, participants explained that they more and more relied on VCFSE organisations as they saw a decline in local activities led by the Local Authority. They also witnessed a decline in investment in local services for their communities – groups talked about some local leisure centres and local children centres closing down.

> *" Different governments have different views on education, child safeguarding, etcetera. It means some services get funded or defunded from one government to another. Some key services need to be protected, so regardless of who's in power we know some of the key services will always be there when needed. We don't care who's in power – we care about what's available to us. And we need to keep the 0-5 services protected, no matter what."*

There was a consensus across all community groups that the government did not care about public health and wellbeing – how could they care about people in underserved areas if they kept on cutting funding and closing leisure centres that are used by community members? Participants instead felt that more investment in community activities and local services was needed to promote healthy lifestyles.

Opportunities to promote physical exercise – such as swimming or children's football – were frequently discussed during the listening events. However, participants talked about not having enough open safe spaces in their local area to let children play. In some local areas, many mothers expressed concerns about their children being too sedentary, and a desire to see more local sporting clubs that would offer outdoor activities in the summer and indoor activities in the winter. Letting children play in the street was not often viewed as a safe alternative, hence the reliance on local leisure centres and community centres. Unfortunately, in several of the wards visited, participants felt that they had limited options. For example, some local leisure centres/swimming pools had closed down, after being defunded by the Local Authority. While in some cases the leisure centres that had closed down were replaced by new ones (in a different area), these were not always accessible to participants who did not drive, and who found the commute by public transport to be too difficult. This meant that some participants had to rely on VCFSE organisations to provide services that used to be offered by the Local Authority. However, these VCFSE organisations found it difficult to operate effectively given the lack of funding opportunities. For example, the Huda centre, whilst still open, had not been able to secure any funding in the past six years. Participants described feeling at the mercy of local, regional, and national politics, who made decisions on their behalf but not in their best interest.

Student participants also raised concerns about their health and wellbeing. For example, many described not being able to cook properly (either because of a lack of money, or a lack of time). They knew they were not eating as healthily as they should, and expressed a desire to get more support. Many students were also worried about the cost of living and not being able to afford food. It is important to note the data was collected just before April 2022, so prior to the ongoing cost-of-living crisis, which mean that students are likely to find it even more difficult nowadays. Several participants described having to find a placement as a significant source of stress, especially as the income from these placements would be directly related to their cost-of-living concerns. International students felt there should be more pastoral support available for them, to support them with their wellbeing. Many of them felt the legacy of COVID-19 and expressed feeling left out, isolated, and unsupported.

As with GP services needing to be more culturally competent, publicly funded local services (where available) also needed to show this competence in the provision of the activities they offered. Women were keen to keep themselves fit and healthy through healthy food choices and physical activities such as Zumba classes and swimming. However, in their localities there were a limited numbers of sessions available for women only, which, given that many participants were from a faith or cultural background where mixed classes were not acceptable to them, meant that they could not find adequate classes/leisure centres. When classes were available, travel was often needed, which most participants could not use as it often conflicted with caring responsibilities. For example, Newtown local swimming pool was a favourite centre for many female participants, as it offered women-only sessions. However, the swimming pool closed down, and the next nearest local swimming pool (which also requires commuting) did not offer women-only sessions.

4.4.2. Need for more local support – not less

There was interest from participants to be able to access health and wellbeing information outside primary and secondary care provided by the NHS, as services have become too difficult to access. Relying on 'health champions' within their community settings was considered an effective way to promote health literacy within familiar and trusted structures. It was suggested that basic health literacy training programmes were made available to community actors, such as community centres, local charities but also hairdressers/nail bars, etc.

Participants explained they would welcome seeing on windows a sticker or label that was provided by the NHS or Public Health to indicate that the people in the premises had received a course on health literacy. For example, some women said they would find it useful if their trusted hairdressers were the ones to remind them to check their breasts and what to look out for to spot possible signs of breast cancer. This would enable conversations to start, and community members to seek medical advice sooner rather than later. Due to the difficulties encountered to access primary (and secondary) care, too many participants stated that they either stopped going to the GP, or often went when it was rather late. Many participants also stated that they wanted mental health community champions. Community leaders suggested that the NHS works with them to train mental health champions so that local organisations feel equipped to support their service users with mental health.

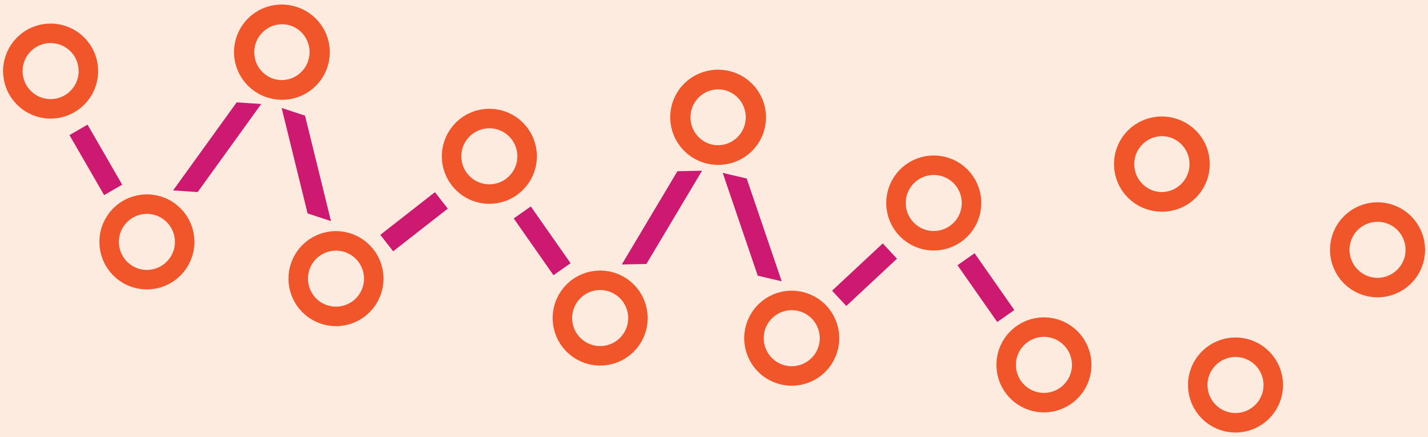
Many participants found support from their local community centres, but talked about the desire to make sure that the information that was relayed to them was in line with NHS guidance. For example, participants wanted a physiotherapist to visit centres to provide tips on what to do/what not to do promote healthy ageing and mobility, especially as many participants described having increased mobility issues.

Participants explained that as they now trusted their community anchors in the voluntary, community, faith, social enterprise (VCFSE) sector more than the NHS. Moving some services and providing guidance within the community was seen as a possible way to encourage better participation. Participants therefore welcomed hyperlocal projects that promote health and wellbeing and talked about training community leaders within the VCFSE sector. Examples of what could be offered included: exercise support, basic physiotherapy, advice surgeries (including how to access healthcare services and knowing their rights), nurse drop-in sessions, wellbeing clinics in partnership with the NHS.

Participants shared positive stories of encountering support for people with diabetes, which they thought could serve as a model for developing other workshops on health and wellbeing. Indeed, participants with type-2 diabetes were able to access workshop at their local centres, which they found helpful. These workshops currently run once a week, and participants stated that they would welcome more. Participants with type-2 diabetes explained that they understood the need to change their lifestyle and diets, but actually found it difficult to (re-)establish a healthy routine without support and/or to amend their diets altogether. They explained that it was thanks to local workshops that they were able to take steps in the right direction.

In addition to supporting health literacy within their community settings, participants also expressed that they wanted to see more investment in developing skills that are necessary to live healthy lives. Digital access and competency were identified as priority areas. This included having access to community-based computers and adequate technology, such as tablets and smartphones, so that community members could teach service users how to navigate health forms, how to book appointments online, and how to navigate online consultations. Providing ESOL classes (English for Speakers of Other Languages) was another priority area identified. Finally, having access to local facilities to enable people to meet and share activities (e.g. sewing clothes) was also identified as needed to promote overall health and wellbeing by reducing isolation. In one group, there was an appetite to support residents to build on their skills to start their entrepreneurial journey to bring in additional income.

Locally, low income was identified as an issue across all community groups, and there was a concern that the wider determinants of health (e.g. poor housing, poor air quality) were worsened by the lack of services available to residents and the difficulties so many of them had in accessing health services regularly. Concerns raised by participants included the lack of affordable housing and increased homelessness in their communities, and no sick pay for care workers. Participants wanted more support/training to find a job, such as a job club, where they could learn how to write/enhance their CVs, do mock job interviews, etc.



5. The community sandpit event and funded projects

The findings from the five listening events were presented during a community sandpit event. The event was attended by all community partners, as well as four other community-led organisations who responded to an invitation to attend the sandpit (see section 3 for more details). On the day, the team and all community partners met together to:

- Reconvene together as a team, and share views
- Involve new community partners that also strive to tackle health inequalities in other areas of East and West Birmingham
- Share findings from the data collected, and provide opportunities for discussion/comments
- Identify key priorities for East and West Birmingham to support local residents' health and wellbeing
- Propose hyperlocal projects to help tackle health inequalities

A total of £6,390 was made available by Aston University and Birmingham Community Healthcare NHS Foundation Trust (BCHC) to support voluntary, community, faith, and social enterprise (VCFSE) partners to implement solutions in their areas. Applying for funding was part of the session and participants were supported to complete the short application form on the day. The aim was to take away some of the barriers VCFSE groups experience when applying for funding such as not having a person dedicated to writing funding applications or having to be registered on a specific tendering system. Five projects were awarded funding:

- The Sewing Project (Aspire & Succeed)
- Community Digital Access to Healthy Living (Age Concern Birmingham)
- Soil to the Boil (Welcome Change CIC)
- Health Literacy Empowerment Rolling Sessions (Saathi House)
- Demystifying the NHS (BLESST Centre & Bringing Hope)

5.1. The Sewing Project – Aspire and Succeed

Aspire & Succeed run a weekly coffee morning for women, where they come together and talk, share ideas and socialise. Out of the listening events, women shared that they would like to learn new skills, and be given more opportunities to leave the house and tackle social isolation. Many women shared feeling isolated, especially since COVID-19 and a series of lockdowns, which affected their mental health and wellbeing.

During the listening events, many women explained that they were very interested in learning how to sew, and pick up new skills.

When presented with the data, Aspire & Succeed proposed launching a weekly sewing club on their premises to help women by:

- Reducing isolation
- Increasing confidence and self-esteem
- Developing new skills
- Enhancing mental health and general wellbeing
- Enabling women to use sewing as an income stream

LADIES ONLY

Sew & Chat

Come along and join our weekly sewing classes, where you can enjoy a cuppa, socialise and learn dress making & sewing skills

MONDAY'S
10AM-12PM

This course will enable you to learn basic skills and then go on to learn advance skills if you are interested in setting up your own tailoring business from home

Aspire & Succeed
3a Carpenters Road
Lozells
Birmingham
B19 2BA

0121 507 0218
07901198198
info@aspireandsucceed.org
www.aspireandsucceed.org

FUNDED BY

Aspire & Succeed was awarded £2,160 to buy sewing machines in order to launch the sewing club. The funding was also used to hire someone who equipped women with the skills to sew.

Since September 2022, around 30 women have joined the sewing club, which is proving very popular. Some skilled women within the group have taken a leadership role, and are teaching the rest of the group how to sew. As a result of the club, some women have even launched their own businesses, and are now able to have access to more disposable income.

Women who joined the sewing club have also increased their linguistic skills – due to the diversity amongst the group, women have had to use English as the main language to communicate and were not able to rely on their mother tongues. This has been excellent for most as language had been identified as a barrier to learning, and participants felts that this activity has helped them to tackle this barrier to some extent.

Thanks to the sewing club, participants have also built the confidence to move on to other courses to pick up new skills, such as IT classes. For example, some of the participants have since then successfully completed IT training and have been taken on as paid volunteers at Aspire & Succeed's summer holiday club to support children and young people.

5.2. Community Digital Access to Healthy Living – Age Concern Birmingham

Age Concern Birmingham received £1,150 to buy IT equipment such as laptops, tablets, and tablet cases. The aim was to launch a digital library to increase digital literacy and confidence among people aged fifty and over. The tablets are being used to provide training to members of the community who are currently digitally excluded.

Thanks to the tablets, community members are also able to access information about healthy eating and recipe apps such as Whisk (now Samsung Food).

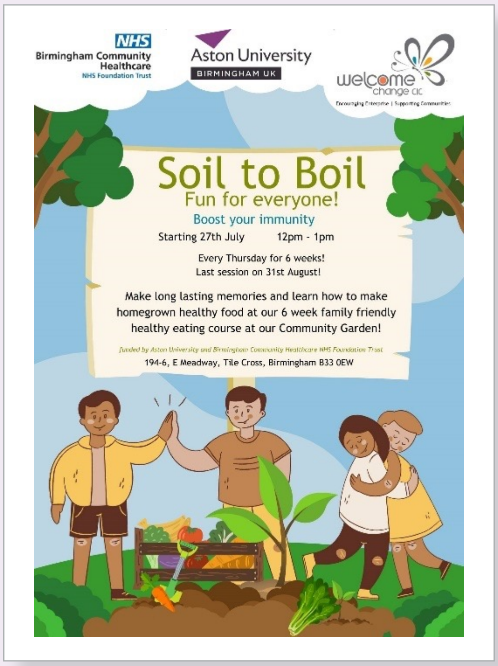
Through the scheme, members of the public were able to borrow tablets and laptops, and learn new IT skills. Some of the people who received the training became volunteers and helped Age Concern deliver the training to communities that have traditionally been underserved. For example, a participant, who was visually impaired and who felt isolated, not only discovered that there were tools available for him to use IT equipment, but also felt empowered by the training and became a trained volunteer and explained that the scheme helped him meet more people.

Moving forward, Age Concern will launch a photo competition to encourage people to cook healthy meals and show off their creations.

5.3. Soil to the Boil – Welcome Change CIC

Welcome Change CIC was awarded £800 to launch outdoor growing and cooking classes during the 2022 summer holidays. The scheme was aimed at children and young people of school age, and their families. The aim was to encourage children and young people to eat more healthily (the area is characterised by low access to healthy food, and high levels of childhood obesity) and spend more time outdoors. The group met once a week in Welcome Change CIC's community gardens and helped foster outdoor cross-generational activities.

Welcome Change CIC reported witnessing behavioural changes during the project, as children and young people planted fruits and vegetables, took pride in their work, and started eating their own produce. Families reported seeing a shift in behaviour as children who took part in the scheme asked to be involved in cooking food at home, and started asking more questions about where food came from and how to eat well.


NHS
Birmingham Community Healthcare
NHS Foundation Trust

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welcome change cic
Encouraging Enterprise | Supporting Communities

Soil to Boil
Fun for everyone!
Boost your immunity
Starting 27th July 12pm - 1pm

Every Thursday for 6 weeks!
Last session on 31st August!

Make long lasting memories and learn how to make homegrown healthy food at our 6 week family friendly healthy eating course at our Community Garden!

Funded by Aston University and Birmingham Community Healthcare NHS Foundation Trust
194-6, E Meadway, Tile Cross, Birmingham B33 0EW

As the scheme proved very popular, Welcome Change CIC secured more funding and was able to re-launch the scheme during the summer school holidays in 2023.

5.4. Health Literacy Empowerment Rolling Sessions – Saathi House

Saathi House's proposal sought to reduce health inequalities by increasing health literacy among women, and develop health champions within their community. As part of their Community Connexions project, Birmingham Community Healthcare NHS Foundation Trust (BCHC) offered to provide support in the following areas: physiotherapy/pain management, infant feeding, diabetes, and oral health. Healthcare professionals from BCHC attended drop-in sessions at Saathi House where they provided advice, and responded to queries. Aston University offered to provide support in the area of eye health.

To further support Saathi House in their initiative, the team also awarded £700 to enable women to attend gym sessions at a local studio with a personal trainer. The personal trainer showed women how to use gym equipment, and what types of exercise are beneficial to live healthily lives and prevent injuries. Women can now access the local gym studio, knowing how to use the equipment. Around 25 women have joined the gym club.

Women who joined the gym club have also increased their linguistic skills – due to the diversity amongst the group, women have had to use English as the main language to communicate with each other. This has been excellent for most as language had been identified as a barrier to living healthy lives.

5.5. Demystifying the NHS – BLESST Centre and Bringing Hope

Bringing Hope and BLESST were awarded £1,580 to bring the NHS to young people. Initially, the aim was to reconnect children and young people with the NHS by rehumanising the institution and showing that it can be accessible, friendly, and supportive of young people. The project responded to the growing lack of trust in the NHS, and to its lack of visibility in the community – especially among children and young people.

To bring the NHS to children and young people, the team wanted to host a series of events and create original social media content with healthcare professionals, to show the fun and vibrant side of the NHS, and demystify the organisation. Through the projects, the team also wanted to raise awareness of existing health services available to young people, job opportunities available within the NHS, and work toward re-building trust between the NHS and young people.

However, in response to the ongoing mental health crisis, the team asked permission to amend their project at the last minute to support children and young people who were suffering. They instead used the funds to launch a series of summer activities to encourage children and young people to reconnect with one another – beyond social media and digital technologies – and proposed a series of sports events and activities that took children and young people off the streets and increasing violence in the neighbourhood. Around 30 children and young people have taken part in the summer activities.

6. Recommendations

A number of recommendations in this project echo those found in the 2022 BLACHIR report, not only highlighting the relevance of their recommendations, but also demonstrating their relevance beyond Black African and Black Caribbean groups. These include:

1 NHS Trusts to implement compulsory intercultural competence training of healthcare professionals, on a regular basis. The aims are to:

- Help rebuild trust, which is currently lacking between minoritised ethnic and racial communities and the NHS (among other public organisations).
- Help overcome existing biases to tackle discrimination and improve patients' experiences.

2 The Health and Wellbeing Board to work with the Children's Trusts and Children's Strategic Partnerships to help improve the lives of children and young people. The aims are to:

- Make the NHS more visible within community settings so children and young people are increasingly familiar with their presence and the work they do. This can help rebuild trust, and raise awareness of the different services available to children and young people.
- Support children and young people through key periods of change – not only developmental changes (as highlighted in the BLACHIR report), but also important social changes (e.g. after lockdowns; being able to respond to the current mental health crisis).

3 Working collaboratively to support healthier behaviours in underserved areas. Our report specifically calls for the Integrated Care Boards (ICBs) to work with Local Authorities to map out existing provision of leisure centres, swimming pools, and other community centres that promote good health and wellbeing. The aims are to:

- Identify any gaps in provision, and decide how to respond adequately to ensure all communities have equal access to leisure centres and community centres.
- Identify existing provision, and assess whether activities are effectively communicated to local communities (e.g. including in languages other than English and in pictorial form), and whether they are tailored to the needs of the local population (e.g. is the leisure centre easily accessible by public transport? Does the centre/swimming pool offer women-only sessions during school hours when women are more likely to be available?).

4 Working with the voluntary, community, faith and social enterprise (VCFSE) sector to increase health literacy among minoritised ethnic groups. Our report calls for the Health and Wellbeing Boards and ICBs to work collaboratively with VCFSE partners. As the BLACHIR report states, "[i]ncreasing people's skills, knowledge, understanding and confidence (health literacy) to find and use health and social care information and services to make decisions about their health is key to achieving healthier communities." (p. 10). The aims are to:

- Respond to participants' feedback, who called for a more holistic approach to health.
- Equip VCFSE partners with the tools to support good health and wellbeing within their communities.
- Work in partnership with VCFSE partners to co-create health solutions, ensuring these are tailored to the needs of the local communities.
- Acknowledge that VCFSE organisations are more likely to be trusted by residents.
- Recognise that VCFSE are more likely to provide culturally appropriate support.

Our report also makes further recommendations:

5 Integrated Care Boards (ICBs) to communicate clearly where the first port of call is for each type of ailment, which services are accessible without needing GP referral, and how to access secondary care via self-referral. Ideally, in pictorial form to make it easy for everyone to access. The aims are to:

- Reduce the burden on health and social care services.
- Attend to patients in a timelier manner.

6 GP practices to review their policies pertaining to telephone/video consultations, and offer more face-to-face appointments – especially where English is a second language. The aims are to:

- Provide more inclusive services.
- Help rebuild a relationship between the patient and the GP, who increasingly seems to be hard to reach.
- Tackle linguistic barriers (participants whose first language was not English explained that they found it more difficult to understand healthcare professionals when not meeting them face-to-face).

7 **Medical and wider clinical training to include basic interpretation skills. The aims are to:**

- Acknowledge that language barriers can lead to poor health outcomes.
- Equip healthcare professionals with basic skills to support patients whose first language is not English.
- Enhance intercultural competences among healthcare professionals.

8 **Regional and Local Authorities to revise how funding is allocated – too often, small voluntary, community, faith and social enterprise (VCFSE) organisations are not equipped to bid for funding (e.g. lack of time or expertise in writing funding applications), unlike larger organisations. Yet, small VCFSE organisations often promote good health and wellbeing among underserved populations, and have shown that they can make a real difference within their communities. The report calls for Birmingham City Council and the West Midlands Combined Authorities – among other regional bodies – to issue calls for micro-funding to support health and wellbeing in the City, and commends the Birmingham and Solihull Integrated Care System for its innovative Fairer Futures Fund. The aims are to:**

- Build on existing good practice among VCFSE organisations, and scale up existing projects that promote good health and wellbeing.
- Maximise VCFSE organisations' impact in their local communities, by providing them with the adequate resources to support local residents' health and wellbeing.
- Strengthen collaboration between the public and third sectors.

9 **Involve voluntary, community, faith and social enterprise (VCFSE) organisations, and local residents in research. The aims are to:**

- Be more representative and inclusive, as underserved communities are less likely to engage in research when it is not led by the VCFSE sector due to a lack of trust.
- Create a new research culture, that is based on collaboration and community engagement.
- Build capacity within the VCFSE and communities, by equipping them with the skills and resources necessary to work with academics and/or larger institutions, so they can together access new funding opportunities, break silos, and maximise their impact.

7. Concluding remarks

The data presented in this report highlights a range of different issues that impact on access to healthcare services and individual health. It shows communities who live in underserved wards are not only more likely to suffer from poor health outcomes because of the wider determinants of health, but also because they are less likely to be able to have access to primary and secondary healthcare services. This report shows it is not 'just' about living conditions, but also about how public health and council funding cuts are making poorer communities even more vulnerable (IPPR, 2019). As a result, health inequalities are exacerbated – which contrasts with discourses of health equity.

> *"Public health constitutes an 'up-stream' intervention, based on the common-sense idea that it is better to stop someone falling into a stream than it is to fish them out later. Cutting it defies both economic theory and fiscal logic. Economic theory, because those who don't develop avoidable illnesses can often stay in work, with the associated gross value added. Fiscal logic, because treatment is almost always more invasive and more expensive than preventing illness in the first place. These cuts therefore harm people. But less is known about which demographics and communities are experiencing the most harm"* (IPPR, 2019).

Public health constitutes an 'up-stream' intervention, based on the idea that it is better to stop someone falling into a stream than it is to fish them out later. Budget cuts defy both economic theory and fiscal logic. Economic theory, because those who do not develop avoidable illnesses can often stay in work, with the associated gross value added. Fiscal logic, because treatment is almost always more invasive and more expensive than preventing illness in the first place. Budget cuts therefore harm people.

Combined with a growing lack of trust in the NHS (among other public organisations), participants explained that they were more likely to disengage from NHS services. The data also shows that it is often women who bear the burden of navigating a healthcare system that either seems to be too busy for them and their dependents, or that is dismissive of their concerns. This shows the importance to take intersectionality into account – minoritised ethnic women seemed to be among the communities experiencing the most harm, something which is exacerbated if they do not speak English as their first language. This corroborates the findings from the 2022 Ethnic Inequalities in Healthcare Review.

Addressing the lack of cultural competence is crucial in tackling health inequalities among minoritised ethnic and racial communities. To do so effectively, a multifaceted approach that involves collaboration between community partners, policymakers, healthcare providers, and researchers is required. This can be achieved through implementing intercultural competence training programmes for healthcare professionals, ensuring diversity in the workforce and leadership positions, and actively listening to the experiences and concerns of patients from minoritised ethnic and racial backgrounds. In addition, community-led initiatives and engagement strategies are essential to ensure that interventions are tailored to "meet the needs of all sections of society".

The data captured in this report demonstrates that many are turning towards voluntary, community, faith, and social enterprise (VCFSE) organisations for support when it comes to health and wellbeing (sometimes instead of, rather than alongside, the NHS). There is therefore an urgent need for stronger partnerships to be developed and supported between the public and third sectors to enable the delivery of specialist services (such as health hubs, and health literacy programmes), and to support healthcare professionals in their work. These partnerships could include developing community-led approaches to health improvement, increasing access to appropriate primary care services, improving access to quality healthcare and improve their health outcomes. An example of such collaboration includes 'Flourish', the West Birmingham Community Health Collaborative – an open group of third sector organisations working in partnership with the NHS and other care providers to reduce health inequalities across Perry Barr and Ladywood (or 'West Birmingham').

The funded projects that emerged from the sandpit event have demonstrated that community organisations can have a positive and meaningful impact on local communities, and that the VCFSE sector should be supported adequately in the work they do to promote good health and wellbeing. While support from healthcare professionals would be welcomed, there is also a need to provide more funding opportunities (including micro-grants and micro-funding) within local government. This could build on existing good practice within the Birmingham and Solihull Integrated Care System (e.g. Fairer Futures Fund).

Overall, there is a need to ensure that we work together to improve the health of our communities and help to build on our strengths as a city to deliver high-quality care that meets the needs of all local residents.

Infographic 1

Listening to 'under-served' voices is not enough

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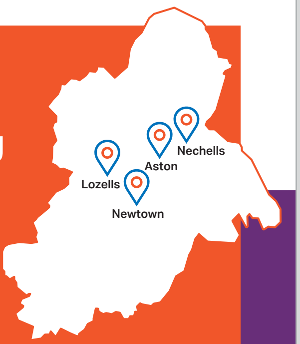
Birmingham Community Healthcare
NHS Foundation Trust

Listening to 'under-served' voices is not enough - new methodologies for community engagement in public health

5 Listening Events were held throughout February and March 2022 in Aston, Newtown, Nechells and Lozells.



In 2018, the percentage of **Aston** households where no one aged 16 or over spoke English as their main language was 25.8%.

Lozells resident employment rates are significantly lower than the city average.

Newtown is one of the most deprived wards in the city.

Lack of funding in the system (councils, NHS and for communities) is having a detrimental impact on people's health.

The Project

A total of **£9422** was made available by **Aston University and Birmingham Community Healthcare NHS Foundation Trust** to work with community organisations to tackle health inequalities in some of the most underserved wards in Birmingham.

Method

The data from 5 listening events was presented at a 'community sandpit' to community partner organisations, who then worked collectively to identify key priorities for their localities and proposed solutions to tackle health inequalities.

Outcomes

Awarded **£2160**

The Sewing Project

12 sewing machines were purchased and a weekly sewing class was launched to combat isolation, and enhance mental health.

Awarded **£1150**

Digital support for over 50s

IT equipment was purchased to provide training and support to people aged 50+ who are currently digitally excluded.

Awarded **£800**

Soil to Boil

Allotment sessions to raise awareness about healthy eating, where food comes from, and share recipes with children and their families.

Awarded **£700**

Health Hub

A project about building confidence for women to start exercising and using the gym again.

Awarded **£1580**

NHS Fun Day

Launched a 4-week activity programme in response to the mental health crisis young people are currently facing.

Partners

aspire & SUCCEED
citizens uk
blesst
SH
BRINGING HOPE
welcome change cic
Community Connexions
AGE concern Birmingham
HUDA MASJID & COMMUNITY CENTRE

Infographic 2

Barriers encountered to access NHS services

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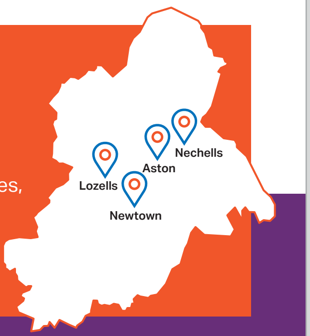
NHS Foundation Trust

5 Listening Events

We listened to underserved communities, who live in wards characterised by high levels of deprivations.



Barriers encountered to access NHS services

Referrals & (Dis)integrated Care

All groups saw access to GPs as the only way to get access to treatment and services.

Examples of barriers include:

- Not being aware of services available without GP referral
- Not knowing about the Patient Advice and Liaison Service (PALS) service
- People being referred around the system and ending up with no diagnosis or no support

Participants reported a lack of continuity of care, both within GP surgeries and with different NHS trusts/services not speaking to each other.

GP Access

All groups encountered great difficulties in accessing their GP, such as:

- Lengthy queuing times when ringing for an appointment
- Limited appointments, especially face-to-face ones
- Overuse of video calls, creating issues for those with poor Internet access or a first language that isn't English
- Lack of adequate professional interpreters

Women disproportionately carried the burden of trying to get an appointment alongside childcare responsibilities.

Maternity & Paediatric Health

Participants across **all four locations** raised issues with maternity care and infant health.

Mums-to-be experienced:

- Feeling like a burden (sometimes due to staff attitude)
- Difficulty accessing antenatal appointments while pregnancy affected their movement
- Lack of continuity of care (e.g. meeting a new midwife at each antenatal appointment)

Once their baby was born, parents experienced:

- Difficulty accessing health visitors
- Face-to-face calls still being unavailable, with most babies not having a single home visit
- Closures of local children's centres, leading to parents feeling isolated and unsupported

New mothers found closures / reduced NHS services particularly stressful, as there was nowhere to ask for help if they had questions about their baby's health.

The listening events revealed that austerity measures have taken a huge toll on underserved populations who are now unable to access NHS services.

Partners

Infographic 3

Barriers encountered within the NHS

Aston University
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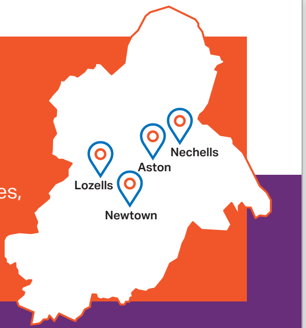
NHS
Birmingham
Community Healthcare
NHS Foundation Trust

5 Listening Events

We listened to underserved communities, who live in wards characterised by high levels of deprivations.



Barriers encountered within NHS services

Language & cultural barriers

4 out of 5 groups reported language as a considerable barrier for effective communication and navigating the healthcare system.

They recounted:

- **Long waits for interpreters, leading to delays and appointment cancellations**
- **Being matched with an interpreter who didn't speak their language**
- **Overreliance on English-speaking family members, due to lack of adequate professional interpreters**
- **Rushed healthcare professionals speaking too fast due to time constraints**
- **Phone consultations being more difficult to follow than face-to-face ones when English is not the first language**

This, alongside a lack of cultural competence has led to an overall lack of trust in the NHS.

Lack of trust in quality of care

Participants described losing trust and confidence in the NHS and found it difficult to feel 'looked after' or like their health concerns were taken seriously.

They felt the NHS was deteriorating, with:

- **No family GPs with whom they could build a relationship**
- **Lengthy referral times, making patients feel overlooked**
- **Communication issues (e.g. not communicating cancelled appointments, or referrals getting lost in the system)**
- **Lengthy queuing times, especially in A&E, making patients feel unsafe**

Many felt uncomfortable or even scared to access healthcare and relied on family members for medical advice, with some looking to alternative medicine over NHS treatments.

Staff attitudes & behaviour

Participants said they met a lot of friendly experienced healthcare staff, but also encountered poor staff attitudes across multiple services and on a number of occasions.

Participants experienced:

- **Feeling unwelcome or like they were a burden**
- **Both subtle and direct rude staff behaviour**
- **Receptionists talking loudly, assuming they didn't speak English**

Several women experienced being told off by midwives for wasting their time and condescending looks while asking about pain or reduced movements.

Subtle rude behaviour examples:

- **Indifferent tone of voice**
- **Poor body language**
- **Avoiding eye contact**

Direct rude behaviour examples:

- **Sighing**
- **Rude language**
- **Rolling eyes**

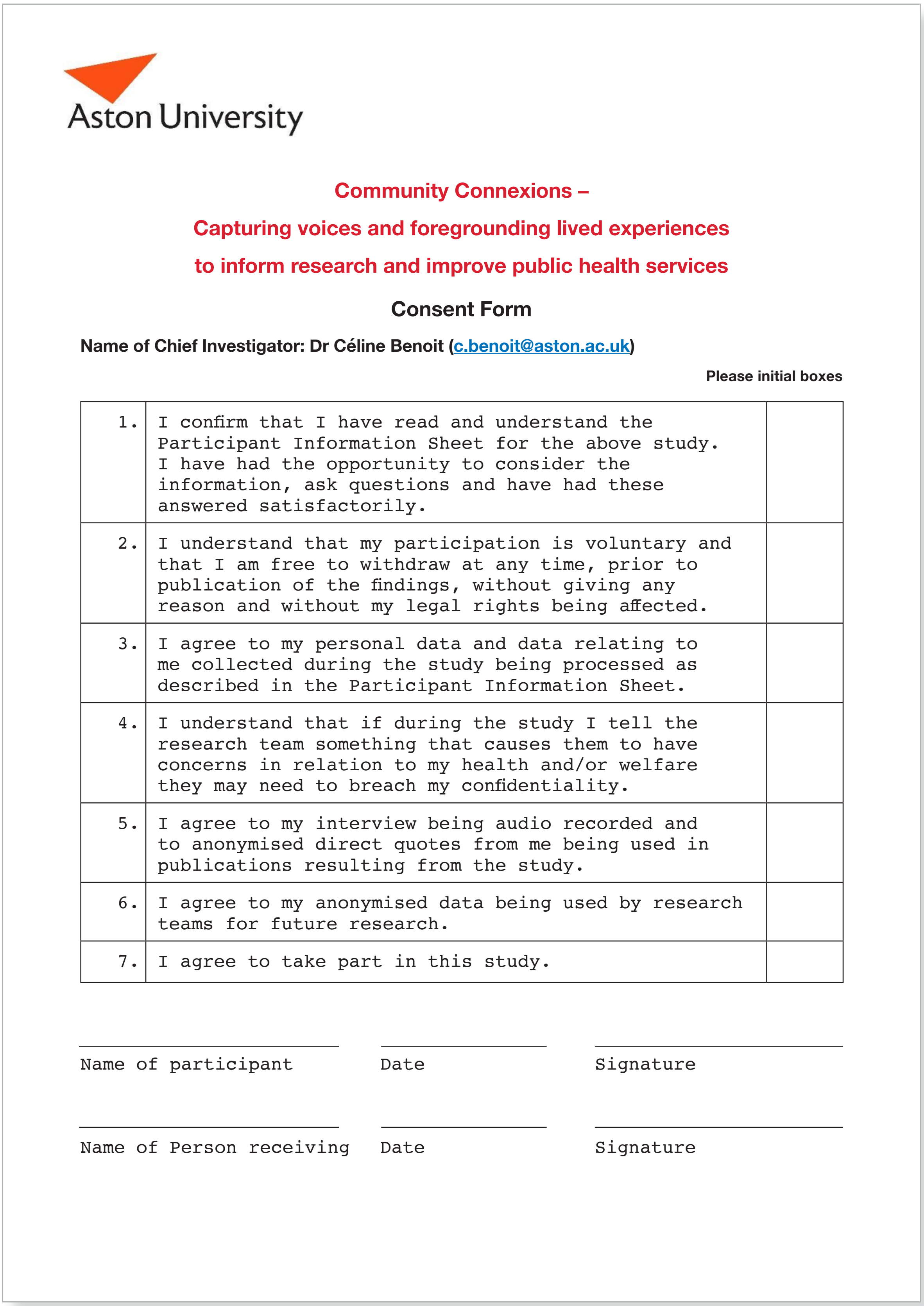
The listening events revealed that NHS staff shortages can have a negative impact on patients' experiences of healthcare.

Partners

aspire & succeed
citizens uk
ASTON STUDENTS' UNION #AstonTogether
blesst
SAATHI HOUSE
Community Connexions
HUDA MASJID & COMMUNITY CENTRE

Appendix 1

Participant consent form



Aston University

Community Connexions –

Capturing voices and foregrounding lived experiences

to inform research and improve public health services

Consent Form

Name of Chief Investigator: Dr Céline Benoit (c.benoit@aston.ac.uk)

Please initial boxes

1.	I confirm that I have read and understand the Participant Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, prior to publication of the findings, without giving any reason and without my legal rights being affected.	
3.	I agree to my personal data and data relating to me collected during the study being processed as described in the Participant Information Sheet.	
4.	I understand that if during the study I tell the research team something that causes them to have concerns in relation to my health and/or welfare they may need to breach my confidentiality.	
5.	I agree to my interview being audio recorded and to anonymised direct quotes from me being used in publications resulting from the study.	
6.	I agree to my anonymised data being used by research teams for future research.	
7.	I agree to take part in this study.	

Name of participant Date Signature

Name of Person receiving Date Signature

Appendix 2

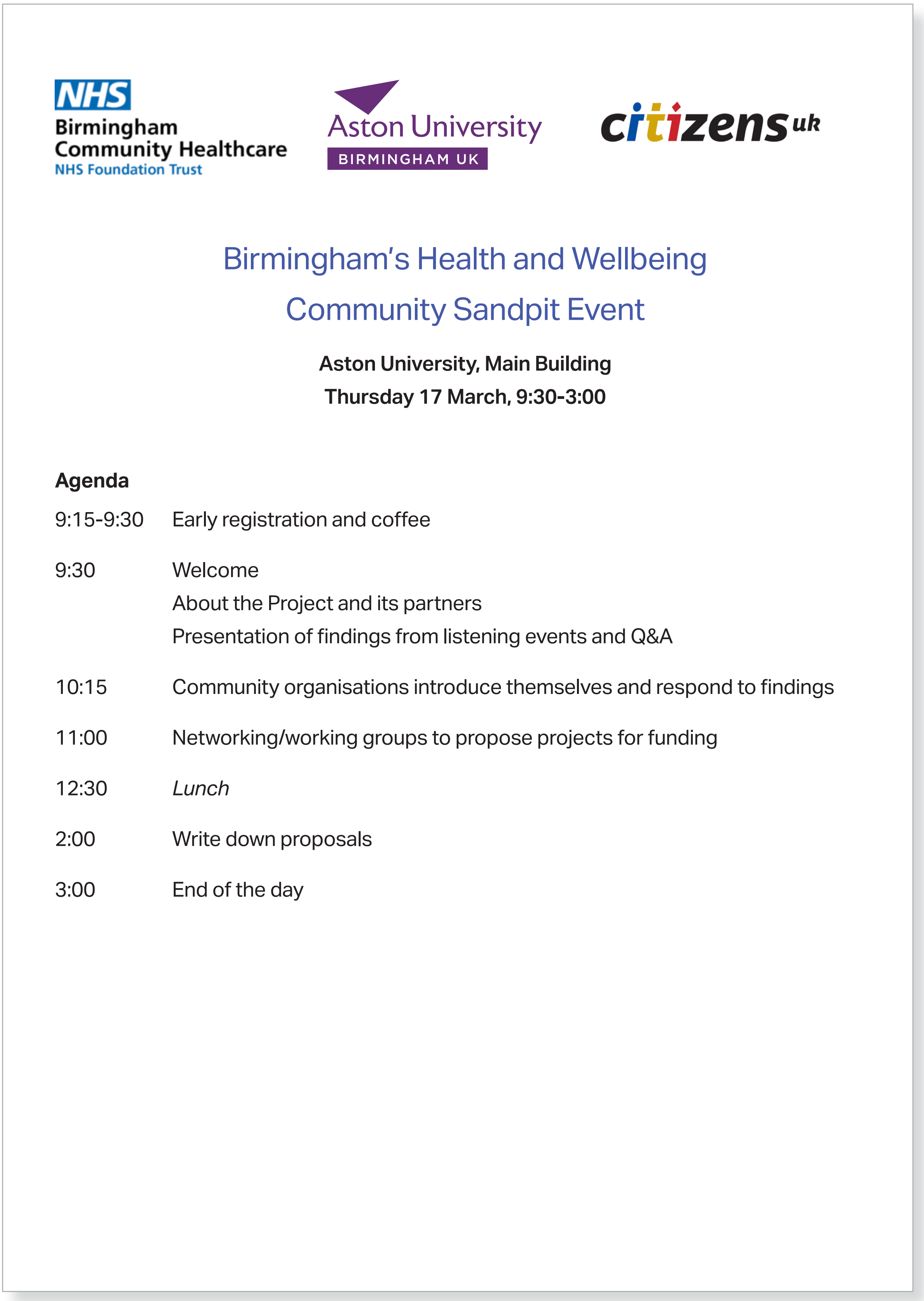
Interview schedule

Questions used to prompt discussion in listening events

1. On a scale of 1-10 how healthy do you feel?
2. What do you see as being the reasons for not being able to stay healthy or be as healthy as you'd like to be?
3. What could the health and care system do better?
4. What would you like to see locally that would help you be healthier?
5. How inclusive are healthcare services? Do you think they are sensitive to your language(s)/culture?
6. How would you like us to keep in touch with you and share any findings?

Appendix 3

Agenda for the community sandpit event



NHS
Birmingham
Community Healthcare
NHS Foundation Trust

Aston University
BIRMINGHAM UK

citizens uk

Birmingham's Health and Wellbeing Community Sandpit Event

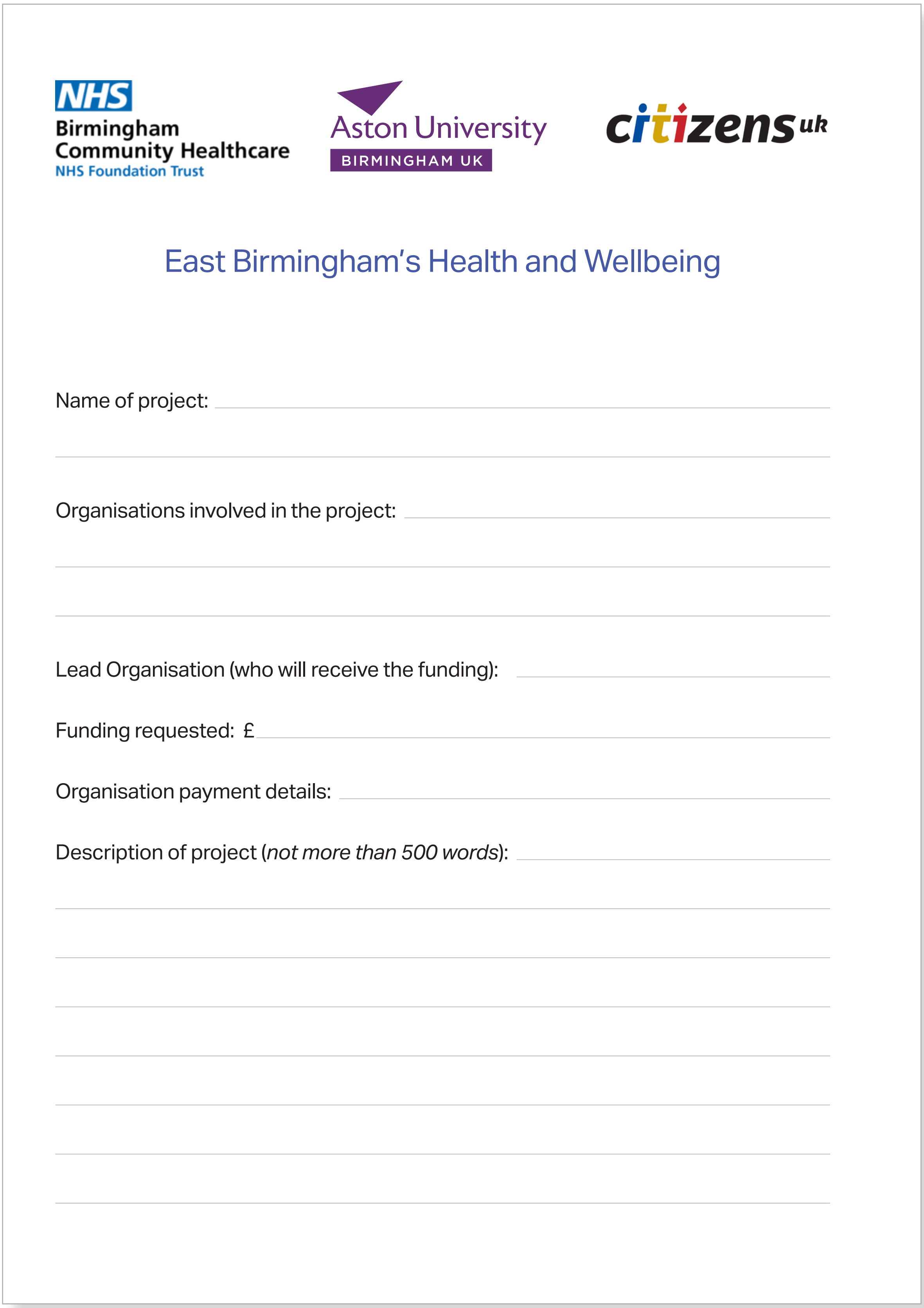
Aston University, Main Building
Thursday 17 March, 9:30-3:00

Agenda

9:15-9:30	Early registration and coffee
9:30	Welcome About the Project and its partners Presentation of findings from listening events and Q&A
10:15	Community organisations introduce themselves and respond to findings
11:00	Networking/working groups to propose projects for funding
12:30	*Lunch*
2:00	Write down proposals
3:00	End of the day

Appendix 4

Project proposal form for the community sandpit event



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East Birmingham's Health and Wellbeing

Name of project: ______________________________

Organisations involved in the project: ______________________________

Lead Organisation (who will receive the funding): ______________________________

Funding requested: £ ______________________________

Organisation payment details: ______________________________

Description of project (*not more than 500 words*): ______________________________

»

List of expected outcomes (*not more than 6 bullet points*)

Breakdown of funding:

Dr Céline Benoit

c.benoit@aston.ac.uk

Centre for Health and Society, Aston University

September 2023