People
Purpose
Passion

NUBIAN LIFE

Manifesto for Improving Adult Social Care outcomes and provision for an aging Black and Minority Ethnic, & Migrant Population

17th May 2017

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INTRODUCTION

This manifesto seeks to gain the support of all political parties, to commit to addressing the need for better provision, and outcomes, in Adult Social Care for aging Black and Minority Ethnic and migrant communities [1](BME & migrant communities) in the United Kingdom.

Nubian Life is not aligned to, and is independent of any political party.

As a service provider Nubian Life believes that it is important that National and Local Government, and Commissioners of adult social care services, acknowledge and recognise that it is crucial for older Black and Minority Ethnic people, to have access to 'Person Centred' services. This means services are tailored to meet specific personal needs, and must contain '**Culturally Specific'** options, grounded in a relevant cultural context, that represent practices and traditions that define an individual's ethnic identification.

The provision of culturally specific options will bring about better overall health and social care outcomes for people from BME and migrant backgrounds. In addition, it is essential that older people from these groups are cared for within the community and home where possible, because issues of isolation, loneliness, social exclusion, and alienation are amplified when social care provision is provided away from family and community networks. Delivering services at home or within the community increases opportunities for family networks to provide additional support. These factors may further help to prevent unnecessary health interventions and hospital admission, thereby easing the strain on services and has the potential to reduce service costs.

Recommendations to achieve this:

1. Ensure individual and cultural needs are taken account of when formulating adult social care and health services.
2. Create a 'minimum standards' guideline for best practice for achieving quality procurement and delivery of culturally specific services for older life provision. These standards should be seen as an integrated part of local Sustainability Transformation Plans (STP).
3. The overarching commentary has to be 'Person Centred', creating an obligation for commissioning groups and providers to demonstrate that they have addressed this issue when procuring or delivering adult social care services.

[1] The term Black and Minority Ethnic (BME) is used throughout this document to define people of all population groups who identify themselves with an ethnicity other than White British. This therefore includes White Irish and White 'Other' ethnic groups (for example Eastern European communities) within the definition.

4. In diverse and metropolitan urban and rural settings, the Commissioning and Procurement of adult social care services should require providers to demonstrate a commitment to diversity and culturally specific services. Providers must also show commitment to developing staff competency in this area. Commissioning bodies such as local authorities should also commit to the above.
5. It is recognised that commissioning bodies and service providers will not necessarily have the prerequisite skills and competence to develop and provide culturally specific services; therefore it is essential that such organisations are encouraged to work in partnership with organisations that already have pedigree in this area like Nubian Life, and similar.
6. National and local government to commit to addressing and reducing health inequalities between older people from BME communities and those from the general population.

The 'Better Care Fund' and the STP are vehicles through which the above recommendation can be facilitated and supported. The Government has recently allocated an extra £2bn for the provision of adult social care, and this provides an opportunity for local authorities and providers to use this extra funding to begin this work.

AGING IN THE UK

Since the post war reconstruction effort provided by the Wind-rush generation in supporting vital services like transport and the NHS, BME and migrant communities have continued to make valuable contributions to British society and the economy. It is widely accepted that without the contribution made by people from overseas, many industry sectors would have struggled, and have only prospered because of the reliance on these groups.

Aging in Britain has become a hot topic for a number of reasons; essentially because the UK population is living longer (and for some healthier lives), and the numbers of older people are increasing significantly. These two factors combine to create unprecedented pressure on the welfare and health care systems, which are already showing serious signs of dysfunction and collapse from the strain.

For an increasing number of people, aging is being approached with a sense of uncertainty and trepidation because of fears about lack of money, little savings and poor pension provision, due to a number of failings in the financial markets which has eroded the value of private and public pension pots. There is growing anxiety by many who felt secure in the belief that the state would provide for them in their old age as long as they paid their national insurance contributions. Unfortunately, the reality for many looking to the state for provision is very different, as it has become clear that the welfare system can no longer honour its guarantee to look after the needs of its citizens from 'the cradle to the grave'.

For older people from BME and migrant communities the situation is made worse because often no consideration is taken of their specific cultural identity and needs in the provision of adult social care. Furthermore, mainstream services often fail to identify and reach the most vulnerable and needy within these communities.

Service providers are facing significant challenges in delivering services in an environment of austerity, where national and local government reduce budgets, and continue to demand huge cost savings year-on-year. This has created very real issues for the long term sustainability and affordability of services in the adult social care sector; and further compounds the challenges faced by older people from BME and migrant communities looking for social care provision.

Whilst longevity is welcomed, it also demands enhanced quality of health care provision for older people, because long term health conditions such as dementia, requires supportive input from professionals as well as family and community.

DISPARITIES IN HEALTH OUTCOMES

"*…some inequalities are not improving – including the poorer health of disabled people, higher levels of mental ill-health among people from LGB and BME groups, lower life expectancy for people with a serious mental illness and over-representation of people from BME groups detained under the Mental Health Act."* CQC

The deferential in health outcomes between the general population and BME and migrant communities is well documented. That this should still exist in the 21st century is unacceptable. Steps must be taken by government and local authorities to address these disparities. One factor in reducing this disparity is the provision of culturally specific services.

DEPRIVATION & HEALTH

A person's quality of life, life chances and outcomes, are heavily influenced by their access to resources, especially those relating to health and education. It has been demonstrated time and again that BME and migrant community group's health prospects are stunted because of the neighbourhoods' where they live. Very often these are densely populated inner city areas, characterised by clusters of groups from specific minority groups with high social needs. Such neighbourhoods often suffer poor air quality and environmental conditions. These are the areas that are most in need of quality services, but have in actuality often received some of the poorest.

BME and migrant communities tend to live in the 10% most deprived areas of the country, with many living in neighbourhoods considered to have multiple deprivations[2]. Deprivation does not just mean poor housing; it impacts and limits access to education, employment and health provision.

Furthermore, BME and migrant groups tend to experience higher mortality rates than the general population, have higher incidence of disability and mental ill health, and significantly higher rates of type2 diabetes. There are also higher rates of hypertension, stroke and cardiovascular disease in the older populations. But despite this BME and migrant groups are less likely to have adequate access to appropriate health information and related services, resulting in poorer health outcomes.

[2] The term multiple deprivation refers to seven dimensions: income, employment, health, education, barriers to housing and services, crime, and living environment.

FINANCIAL EXCLUSION AND SERVICE TAKE-UP

There are a number of factors that go towards explaining why there exists poor health take-up for adult social care provision amongst BME and migrant communities. Some consideration must be given to the fact that many older BME and migrant people are excluded from services because of hidden financial costs associated with accessing these services, for example the cost of transportation, and parking fees attached to hospital and GP parking. Also the impact of eligibility criteria has meant a significant number of older people cannot afford to make the contribution towards the cost of their care, and so do without.

"*Factoring in socio-economic disadvantage, such as low income, does not fully explain the differences in health between ethnic minorities and the majority population. It seems highly likely that other factors, perhaps including the experience of racial discrimination or cultural insensitivity in the provision of health care, are also associated*." King's Fund Briefing (2006)

THE IMPACT OF AUSTERITY ON SOCIAL CARE PROVISION

ONE SIZE FITS ALL - GENERIC SERVICES

The effect of shrinking local authority social care budgets has forced all authorities across the country to review their spending and service coverage. For most this has meant severe cut backs in service provision, while attempting to uphold services on smaller budgets. For others there has been a greater emphasis on encouraging collaborative solutions and working partnerships between agencies. The reality is that many providers have only been able to continue to provide services by cutting back on quality, by providing very basic 'generic' services which force users to fit into a framework that provides no capacity to take account of individual needs.

These solutions have not been particularly successful, and have led to ongoing media criticism of a sector in crisis because of poorly managed services, low staff retention, due to disengaged and demoralised staff caused by poor pay and conditions, and poor training. The real losers in all cases are the users, who are being short changed, as they do not get the service provision that they require, or deserve.

The Care Quality Commission has made it explicitly clear that to be deemed, as 'good', services need to be responsive to the needs of the individual. This can only be achieved if services are 'person centred', allowing the individual to become actively involved in the design of their own care package, and in ongoing discussions which take account of their needs, preferences, and service development plans.

Moreover, the CQC have stated that to achieve improved equality and outcomes for BME and migrant groups within the social care sector, there has to be a system of benchmarking that requires joint involvement, and an integrated approach to service provision and outcome for local communities, which begins with the commissioning bodies, but extends to include all parties involved and responsible for the provision of care services.

CONSEQUENCES OF GENERIC ADULT SOCIAL CARE SERVICES ON AN AGING BME & MIGRANT COMMUNITY

The consequence of generic services especially to BME and migrant communities overlap and intersect several issues. It has been shown that generic services are ineffective in meeting the needs of people from BME and migrant communities. Particularly because these groups are less likely to have input into the commissioning of health and social care services, therefore the offer of appropriate services is not reflected in their care plans, and consequently result in poorer health outcomes compared to the general population.

Even though most service providers have statements or policies on diversity and equality, very few of them actively work to ensure these policies are 'lived' in day-to-day service delivery.

A considerable proportion of older people from BME and migrant communities have a fear of growing old in the UK because of racism and discrimination that they have experienced in the past. As a result there is a significant issue of reduced trust and a lack of confidence for statutory services. For many their ideal is still to return 'home', which sadly for many is an unrealistic goal.

The prevalence of negative perceptions and stereotyping often means that communication and engagement with BME and migrant groups are entered into with preconceived notions about who they are, how they behave; and consequently how they should be treated.

The aging BME and migrant community also face specific health challenges due to the pervasiveness of specific conditions like diabetes, stroke, sickle cell anaemia and dementia.

DEMAND FOR CULTURALLY SPECIFIC SERVICES

Responsiveness to an individual's needs, need to go beyond broad ethnic categorisation, because within these broad definitions are distinct cultural, linguistic and religious variations.

Culturally specific adult social care services is an absolute necessity if we are to truly respond to person centred needs. Culturally specific services means providing services that have meaningful points of reference based on faith, ethnic grouping via staff representation, peer contact, language, news and information, music and art, food and food preparation, and rituals and customs.

It means service provision should be respectful and sensitive to a person's ethnicity, gender, preferences and wishes, with the intent to bring about the best possible health outcome for the individual.

NUBIAN LIFE RESOURCE CENTRE

Nubian Life is a vibrant and successful charity operating as a community care resource centre in the London Borough of Hammersmith and Fulham. It was established in 1995 in direct response to a recognised gap in the service provision within the borough for its aging African Caribbean population.

Nubian Life provides Adult Day Care Services for Older (65 years +) African and African Caribbean residents across the borough. Since its inception it has dedicated itself to creating positive experiences and outcomes for its service users and staff. As a result Nubian Life has established itself as a specialist provider in the adult social care sector, by becoming expert in meeting the individual needs of clients with a range of critical health issues, such as Dementia, Alzheimer's, Diabetes and physical and visual impairments.

Nubian Life has been consistently active within the adult social care and community arena for many years, and has partnered and collaborated with a number of other organisations within the sector to help shape guidelines for best practice and service provision; to give voice to the specific needs of older people accessing community services; and to raise awareness for better funding for the sector. Nubian Life has established itself as a recognised leader in adult social care, creating imaginative and innovative initiatives and events for the community, users and staff.

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