NatCen Social Research

NIHR School for Social Care Research

Research findings

Satisfaction with adult social care among Bangladeshi, Pakistani and white British populations

KEY POINTS FROM THE RESEARCH

- Among the Bangladeshi and Pakistani, and comparison white British, groups studied there were common drivers of social care satisfaction regardless of ethnicity and religion. However, the research identified a number of factors specific to the Bangladeshi and Pakistani groups which affect awareness of services, and how social care is accessed and received that could explain some of the differences in satisfaction. Neither of these groups is homogenous and other factors such as education, whether they were first or second generation migrants and English language skills were also important.
- The cognitive interviewing element of the project found that there were no clear inconsistencies between the groups studied in how social care survey questions are understood. Some issues with the survey design and questions emerged from interviews but there was no evidence that differences in satisfaction result from measurement inconsistency. There were, therefore, genuine differences in satisfaction.
- Local authorities and providers could engage with minority communities, through the media and community organisations, to raise awareness of available services and reduce the stigma associated with accessing services.

People from black and minority ethnic (BME) groups report lower levels of satisfaction than white British people in social care service user experience surveys. This project explored the reasons for these differences through in-depth research with Pakistani, Bangladeshi and white British populations who receive personal social care services at home; with their families as well as with social care providers.

The research looked at people's experiences of receiving care as well as their understanding of questions in satisfaction surveys.

The research was led by Dr Margaret Blake at NatCen Social Research with colleagues Alice Mowlam, Fatima Husain, Valdeep Gill, Rachel Whalley, Kim Vowden, Camille Aznar, Michelle Gray and Meera Balarajan, as well as Alison Bowes, Ghizala Avan, Corinne Greasley-Adams from the University of Stirling and Ghazala Mir from the University of Leeds.

- Service user characteristics and preferences should be taken into account when choosing a package of care to ensure that there is cultural and religious sensitivity. Improved and ongoing training for social workers and care workers on relevant local cultural issues and on how to develop a service user led understanding of needs may improve relationships with care users.
- Communication with those who do not speak English fluently could be improved through workforces that are representative of local populations, greater use of interpreters and better briefing and training of both interpreters and social workers.

The study represents independent research funded by the National Institute for Health Research (NIHR) School for Social Care Research (SSCR). The views expressed are those of the authors and not necessarily those of the NIHR, SSCR, Department of Health, or NHS.

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- A number of steps could be taken in collecting satisfaction data from surveys to improve accessibility for service users of all backgrounds, but particularly for those whose first language is not English or who receive a lot of help from carers in completing questionnaires. Verbal translations may be needed to include people who cannot speak English; community organisations could play a role in raising awareness of surveys and facilitating participation; and clarification needs to be given to carers on their role in completing the questionnaire. Consideration also needs to be given to alternative methods for collecting feedback on satisfaction from those who are unable to participate in surveys.

BACKGROUND

Black and minority ethnic groups (BME) in England consistently report lower satisfaction with social care services than the majority white British population (NHS Information Centre 2012, HSCIC 2013). Previous research shows that the impacts of culture on use and experience of health and social care are nuanced and interact with other factors (Bowes *et al*. 2012). This research aimed to look at what lies behind lower levels of satisfaction with social care by focussing on two groups – Bangladeshi and Pakistani – known to experience particularly high levels of health inequality (Sproston and Mindell 2006) and comparing them with a white British group. The overarching research question was addressed from two angles:

1. What drives satisfaction with and outcomes from local authority adult social care in the three different ethnic groups?

The project explored cultural, language and religious factors which affect how services are sought, accessed and received. The research aimed to understand whether satisfaction is lower because there are differences in awareness of available services, expectations, differences in the quality of care provided, or whether consistent but inappropriate services are provided. This phase of the project involved in-depth interviews with Bangladeshi, Pakistani and white British service users and their families, as well as focus groups and interviews with local authorities and providers.

2. Whether survey questions are understood consistently by the different groups in such a way that satisfaction data can be compared.

The question of whether self completion satisfaction surveys are the most appropriate means of obtaining feedback on satisfaction from these groups was also addressed. Cognitive interviewing was used to explore how social care users understand and respond to satisfaction questionnaires.

A final element of the research involved deliberative workshops to develop recommendations based on the findings.

KEY FINDINGS

Relationships with local authorities and accessing care

There was widespread confusion about the organisation of adult social care services in all groups, particularly among Bangladeshi and Pakistani service users and their relatives who had often struggled on their own for years before finding out about adult social care services. They faced educational, language and cultural barriers to obtaining information.

Service users and relatives from all three ethnic groups alluded to a need to 'fight' for services. Bangladeshi and Pakistani families who were not fluent in English found it extremely challenging to argue their case. Merrell (2006) found similar inequalities in service provision. Furthermore, there were experiences of poor communication by local authorities among all three ethnic groups. Local authority staff believed that a shift from face-to-face communication to telephone contact centres presented particular problems for people who were not fluent in English.

The desire to care for one's own family members without help from external agencies was expressed by some service users of Pakistani and Bangladeshi origin, as was found by Hanley (2007) and Wells and Wagg (2011). There was also some concern about the stigma associated with receiving help from outside. On the other hand, there was a perception among relatives of Bangladeshi and Pakistani service users that it was unfair that local authorities were reluctant to provide a high level of formal care to people living with their families.

There were tensions within families from all three ethnic groups as a result of service users being reliant on care provided by family members, mostly women. These tensions were especially evident among Bangladeshi and Pakistani families where women cared for in-laws, or their disabled children, alongside other responsibilities such as household tasks, formal employment or childcare. Social workers and providers expressed concerns about Pakistani and Bangladeshi women who were acting as main care givers and struggling to cope. Social workers reported that it was sometimes difficult to speak directly with Bangaldeshi or Pakistani women providing care because of language barriers or due to their other responsibilities (e.g. childcare). Interpreters were not always available to support social workers, resulting in other family members being the main point of contact for social workers. Female carers indicated that they needed more help but did not know how to go about getting it and also commented on the need for help from family in communicating with English speakers:

> I have not told this to anyone. … No, whom should I tell? I really don't know. … It would be better if I could get some help for that purpose. It would be good if they could provide with some help. I shall also do the job if they don't give the support. What can I do? (*Relative of female service user, Bangladeshi origin, London*)

Receiving care

Bangladeshi and Pakistani service users and relatives did not necessarily expect their social worker or care workers to speak their language, but they did want them to show cultural sensitivity and to use an interpreter if necessary. Having a good relationship with the social worker and care worker was an important factor in being happy with the care being received.

Service users and relatives expected care workers to be both professional and caring. However, care workers were under demanding time pressures. Time allocated for completing tasks and/or travel between visits was often tight or insufficient. This resulted in tasks not being completed, or service users feeling care workers were rushing and did not care about the work being done.

> They think you are rushing through, but what they don't understand is that you are paid for only 45 minutes. (*Care worker*)

Providers of care received varying levels of information on service users from local authorities, and the type of information differed from one local authority to another. Care providers advocated having an open discussion about the service user's and relatives' preferred gender, ethnicity and language for a care worker since ethnic matching was not desired by all.

Ethnic specialist day opportunities services facilitated social contact with peers, culturally appropriate activities and foods, but were not a source of satisfaction if they were not well run.

Understanding of survey questions

The cognitive testing of survey questions found no evidence that inconsistencies in data collection or understanding of the survey questions lead to inconsistent measurement of satisfaction or social care outcomes. Even for topics such as food and drink where preferences and requirements may be different, the survey questions acted as consistent measurement tools. However, the cognitive interviewing did identify a few issues with the survey questions, which particularly affected Bangladeshi and Pakistani groups:

- Inappropriate translations of the questionnaire with questions not well understood and low uptake for translated versions;
- Carers and other family members are sometimes confused about how to answer the questions, meaning the views of carers rather than service users are sometimes captured;
- Some words and phrases are not well understood (across all ethnic groups);
- Respondents are not always thinking about the specific service intended when answering the questions.

CONCLUSIONS

The overall conclusion of this research is that lower levels of satisfaction among Bangladeshi and Pakistani service users than among white

British service users result from barriers to access, provision which is not appropriate, or which is culturally adapted but in such a way that it does not reflect the preferences of service users and their families. The key recommendation flowing from this is that when providing care to a culturally diverse population, a person-centred approach is needed, based on an understanding of people's cultural, linguistic and religious background without making assumptions. Care needs to be culturally sensitive but also sensitive to other aspects of the service user's circumstances because the impact of ethnicity on care needs is nuanced.

We found that carefully administered satisfaction surveys measure satisfaction consistently and do highlight genuine differences in satisfaction between groups.

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ABOUT THE STUDY

The study was conducted between January 2012 and December 2013 by NatCen. The study included:

- Qualitative in-depth interviews (61) with social care recipients and their families (see Gill *et al.* 2014);
- Cognitive interviews (34) with social care recipients and their families (see Gray *et al.* 2014);
- Focus groups (4) and in-depth interviews (7) with local authority staff and social care providers (see Gill *et al.* 2014).
- Three deliberative workshops with practitioners and users to develop recommendations for meeting diverse user needs (see Gill *et al.* 2014).

Social care users included in this study were aged 18 and over, had a range of health conditions and disabilities and were of Pakistani, Bangladeshi or white British ethnicity. They were in receipt of local authority-funded adult social care or had been in the last 12 months at the point of data collection. Homecare was the most common form of formal care, followed by attendance at day opportunities services and home adaptations. The sample included participants who were in receipt of personal budgets. Interviews were conducted with relatives of eligible service users, where the service used was not able to participate themselves.

The study was conducted in three areas of England: London, Birmingham and Leeds.

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