

Satisfaction with social care services among South Asian and White British groups

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In national surveys, people from Black and Minority Ethnic (BME) groups have generally reported lower levels of satisfaction with social care services when compared with White people (NHS Information Centre, 2012). It is vital to investigate why this is the case so that services can be improved, particularly as there may be a greater need to use services due to higher levels of ill health and disability among certain minority ethnic groups. Utilising qualitative in-depth interviews with people from South Asian and White British groups in Hampshire, Portsmouth, and Southampton, this study compared experiences with social care services across the two groups. The project aimed to suggest improvements for the benefit of both groups.

Key Points

- There were both differences (e.g. language issues) and similarities (e.g. the importance of care staff having a kind manner) between South Asian and White British service users and family carers.
- People with a good understanding of the social care system were more in control of their care. People with a poor understanding were uncertain about how to access further care, or why a service had been refused or withdrawn. More White British than South Asian people had a good understanding of the social care system.
- Recommendations include: thorough assessments, meeting language needs, accessible named social care staff, and better communication to service users and family carers throughout the whole social care process.

Introduction

Since 2001-2 local authorities with responsibilities for social care have participated in national surveys of client experience and satisfaction (Francis & Netten, 2004). The User Experience Surveys capture demographic information about clients, including age, gender and ethnicity, which allows the monitoring of equality standards as set out in the Equality Act (2010). There have been consistent findings showing that people from BME groups have been less satisfied with services received compared with the White group. However, the

nature of the survey questions does not allow a full exploration of the thought process behind the satisfaction evaluation. The aim of this study was to use qualitative methods to explore the reasons why people from minority ethnic groups, specifically South Asian groups, might have different reasons for satisfaction with adult social care services when compared with the majority group, specifically the White British group.

The study

This research was conducted in Hampshire, Southampton and Portsmouth, where there is a

sizeable population of South Asian people. Qualitative interviews were conducted with people from South Asian groups to explore their experiences with social care services. A White British comparison group was also interviewed to see how similar or different their experiences were to the South Asian participants. Individual in-depth interviews were carried out with 121 participants, comprising 46 service users, 36 family carers, and 39 social care practitioners. Interviews were carried out in English, Hindi, or Gujarati, depending on the participant's preference. Within the service user and family carer groups there were 39 people from South Asian backgrounds and 43 people from White British backgrounds. The practitioners were from a range of ethnicities.

Findings

Help seeking

Participants were asked how they had come into contact with social care services. Four types of help seekers were identified: medically-focused, word-of-mouth, enablers and informed. Participants from both the South Asian and White British groups were found in all categories.

The medically-focused participants believed that the general practitioner (GP) or hospital was the appropriate place to find out about social care services. However, some reported that they had not been able to find the information they sought from these health services. The word-of-mouth participants had not known how to get in touch with social care services in the first place, and had only found out through conversations with friends or relatives who already knew about them. The enablers helped other people to access services by passing on information. The informed participants knew how to find out about services, and some used the internet to look for quality ratings. They had this knowledge from past experience as a service user or carer, or from having worked for social services.

The most common strategies were word-of-mouth, which is dependent on knowing the right people, and medically-focused, which was not always successful. A key finding was that many participants did not know how to ask for help from social care services. Furthermore, even though

participants had accessed one type of service, many were unsure what else was available.

Differences between South Asian and White British participants

The differences between the South Asian and White British experiences fall into two main aspects: (i) the aspects specific to being part of a religious, linguistic, ethnic, and/or cultural minority, and (ii) the aspects related to understanding the social care system.

1. Specific issues - South Asian participants

South Asian participants emphasised that language needs ought to be met within social care services, but in their experience these needs were not usually met within mainstream services. For example, one family carer reported that his Punjabi speaking mother was unable to tell the English speaking domiciliary carers that she needed a painkiller. Culturally specific services or language-matched practitioners were preferable to services where staff spoke only English.

A wish for appropriate food was expressed strongly. The definition of 'appropriate' food varied considerably depending on the religious background of the participants. Many Hindu and Sikh participants preferred vegetarian food, Muslim participants required halal meat, while members of Jainism and the *Swaminarayan Dharma* Hindu sect could not eat onions or garlic. Appropriate food was obtained at culturally specific services, such as an Asian carers' group or lunch club. There were examples of meals-on-wheels providing Indian food. One carer was concerned about his vegetarian father with dementia accidentally eating the wrong food, and thought that meat and vegetarian food should be served in separate areas.

Unfortunately, there were some examples of experiences of racism and discrimination within social care services. Other people felt they had been treated unfairly compared to others, but not linked to racism.

Many within the South Asian sample preferred that people's care needs were met within the family, where possible, but a few considered that this viewpoint was becoming less common. Such expectations may well influence people's evaluation

of the quality of social care services. The expectation of family care was used negatively in one case, where a South Asian carer felt ashamed to ask for respite care because of services' assumption that he would not wish to use it. This finding shows the continued negative impact of the assumption that minority ethnic families prefer to 'look after their own'. On the contrary, some Asian participants reported that services were indeed desired once a certain level of need was reached. Therefore, in this study the use of social care services was not incompatible with the view that family care is preferred.

2. *Understanding the system*

The second main aspect of the differences between the South Asian and White British participants was their understanding of the social care system. More White British than South Asian participants had a good understanding of the system, including issues of structure such as funding, eligibility, and boundaries between local authorities.

Participants with a good understanding of social care services were better able to work with the system in order to gain the services they needed. Participants with a poor understanding were unable to access what they needed, or were uncertain why a service had been refused, leading to frustration and lower satisfaction. Inaccurate expectations about what could be offered, e.g. expecting more hours of care, led to dissatisfaction.

Some participants reported that practitioners wanted to meet the needs of service users, but the way they expressed this was by asking the service users what they needed. Without being aware of the range of help that social care services can provide, and perhaps more importantly what they cannot do, service users were unable to give this answer. This led to unmet need.

Several of the White British participants also had a poor understanding of the services, reporting a lack of awareness of how to get help and a lack of information. The difficulties this group experienced ought not to be underestimated, and shows that outreach is needed not only among BME groups. However, these issues are particularly problematic for the South Asian group, who had additional barriers to this knowledge including migrating

relatively recently, language barriers, and outreach not 'reaching' sufficiently.

Shared sources of satisfaction and dissatisfaction

The manner of individual social care staff was important to both White British and South Asian participants in the study, especially warmth, a caring attitude, and being understanding.

Continuity of social care staff was also valued, although not often achieved. Participants pointed out how continuity of staff was important for building a sense of trust in people receiving intimate personal care, such as bathing. Service users also enjoyed building up a friendship with domiciliary care staff. Participants wanted to have a named social worker throughout their contact with services, rather than being removed from a caseload after the care plan had been arranged.

White British and, to a lesser extent, South Asian participants both reported being unhappy with the unreliability about the time domiciliary care workers would arrive. The length of time taken for a service to be provided was described as unreasonably long in several interviews.

Where continuity of domiciliary care workers was not possible, it was important that the worker had time to read the care plan before visiting. Several participants said that the care worker had not read the plan, and some service users were either too embarrassed to ask for help (e.g. with bathing), or did not have the English language skills to explain what they needed.

A repeated discussion was the negative impact of no longer receiving a service that participants had greatly valued. Several services had been withdrawn due to budget cuts. These participants felt that the importance of the service to their lives had been underestimated, and they had not been offered anything adequate to replace it. Both White British and South Asian participants had been negatively affected by the closure of a valued service.

Recommendations for practice

There should be better communication throughout the entire social care process, from outreach to

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post-discharge, to ensure service users and family carers have accurate expectations and a better understanding of social care services. Social care services are keen to empower service users to make their own decisions about care, but service users need to understand what is available before making these decisions.

The project team's experience recruiting participants for this study showed that information stalls at places of worship were very effective ways of sharing information about the research. Similar approaches could be taken for outreach events to raise awareness about social care services.

Providing more information about social care services through GPs and hospitals will be particularly useful – this is where many people expect to find out about social care services. Since participants clearly expected their GP to know about social care services, GPs should be provided with training and information about social care services, and also to have the ability to refer patients to social care services directly. Some local authorities are already doing good work in this regard.

Trust between service user and care staff is developed over time, so having the same staff member as often as possible is recommended. Although continuity of domiciliary care worker cannot always be guaranteed, in these cases it is particularly important that the care worker has sufficient time to familiarise themselves with the care plan.

Language needs should be met at all stages, not only at first assessment. Although culturally specific services are clearly meeting these needs, such services are at risk of closure due to funding cuts. Alternative ways of meeting the language needs of clients could be considered. These include employing care staff with appropriate language skills, and equipping English-speaking staff with key vocabulary, for example.

Catering guidelines could clarify whether service users have specific dietary needs, especially if they have a cognitive impairment.

Few participants were entirely happy or entirely unhappy with their social care services experience, but these nuances were not captured by the satisfaction survey. More opportunity for service users to convey their whole experience would be welcome, e.g. through face-to-face discussions.

Overall, the study has revealed that in the climate of funding restrictions, service providers are struggling to meet the needs of all clients and carers. However, the findings show that service users and carers can be satisfied with services, providing their understanding of the service are facilitated by good communication at all stages. This finding applies equally to South Asian and White British service users and family carers, but communication efforts need to be even more concerted for minority groups.

Finally, the project team would like to thank all of the people who took part in the interviews, and who helped with the organising of the research.

This paper presents 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 SSCR, the NHS, the NIHR or the Department of Health.

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