

Perceptions of Health Inequalities in Milton Keynes



Image source: <https://bit.ly/37eink8>

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Key words and Abbreviations

Key word/ Abbreviation	Meaning
Health disparity	Differences in health between individuals or groups
Socio economic status (SES)	Social standing or class and wealth of an individual or group
Prevalence	The proportion of a population who have a specific characteristic in a given time period
Deprived/ deprivation	Disadvantaged/ suffering a severe and damaging lack of basic material and cultural benefits
Disproportionate	Too large or too small in comparison with something else
YLL	Years of life lost- a measure of premature mortality that takes into account both the frequency of deaths and the age at which it occurs (per 100 000 per population)
Wider determinants of health	Social, economic and environmental factors that influence health, well-being and inequalities
MKUH	Milton Keynes University Hospital
VCSE	Voluntary, Community and Social Enterprise
NHSE/I	The merger of National Health Service England (NHSE) and National Health Service Improvement (NHSI)
Cis	A term used in science to mean 'same' just as trans is a word used in science to mean 'opposite'. Cis is commonly used to describe people whose sense of personal

	identity and gender corresponds with their birth sex
LGBTQIA+	lesbian, gay, bisexual, transgender, queer (or questioning), Intersex, Asexual. Adding a "+" to the acronym is an acknowledgment that there are non-cisgender and non-straight identities that are not included in the acronym. This is a shorthand or umbrella term for all people who have a non-normative gender identity or sexual orientation.

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We would like to thank the 617 Milton Keynes people who shared their experiences and their ideas for solutions.

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Anchor Hanover Housing Milton Keynes

Milton Keynes Urgent Care Centre

Woughton Parish Council

Great Linford Community Larder

SOFEA Community Larder

Rethink

Whitehouse Surgery

Lakes Estate Community Centre

Netherfield Meeting Place

The Rowans Family Centre

Bar Bar Café

Namji Restaurant

Q:Alliance

CNWL Mental Health Services (CAMHS, Specialist Memory Service, Perinatal Mental Health, IAPT)

Alzheimer's Society

Terrence Higgins Trust

iCASH

Parents and Carers Alliance (PACA)

YiS Young People's Mental Health

Age UK Milton Keynes Live Life Social Prescribing

MK Melting Pot

Milton Keynes Council Care and Response Community Alarm Service

Milton Keynes Macular Society Support Group

Carers MK

MoreLife

Mind BLMK

MK Prostate Cancer Support

Milton Keynes University Hospital Breast Care Team

Better Housing Better Health/ National Energy Foundation

Maternity:MK

Kooth

Ride High

Xyla Health and Wellbeing

Diabetes UK: MK

Milton Keynes University Hospital Diabetic Eye Clinic team

AVMK Sexual Assault and Abuse Support Service

MK ACT

Public Health

Cat Armour aka The Hormone Fairy

1 What are Health Inequalities?

When people talk about access to health or care services being a 'postcode lottery', they are really describing inequality.

Health inequalities are the unfair, avoidable, and systemic differences in health, health services available, and health outcomes (how people keep their level of health or how their health is improved by treatment) between different groups of people¹.

These inequalities are often so deeply embedded within society that they can be hard to see as anything but 'normal' or 'natural'. It is widely acknowledged that people facing poverty, racial inequality, and/ or gender inequality are more likely to have a lower socio-economic status (SES) due to their income, education, and background. These groups of people have limited means and fewer opportunities to lead healthy lives compared to their people with a higher SES. They experience a more varied access to services and report poorer satisfaction of care which also contributes negatively to their health status.

These differences can be seen within a particular population by looking at life expectancy and prevalence of health conditions. Men and women living in the least deprived parts of MK enjoy over 11 years more in good health than those living in the most deprived areas. A baby boy born in MK in 2019 can expect to live for 79.1 years and a baby girl for 83.1 years. Babies born in the most affluent parts of MK will live around 7.5 years longer than those born in the most deprived areas. This gap has widened over the last five years for women.²

Our health is shaped by many factors. These are referred to as the wider determinants of health. Examples include age, sex, hereditary factors, individual lifestyle factors, social and community networks, living and working conditions (education, employment, housing, health & social care services) and general SES, cultural and environmental conditions all which enable health inequalities to arise when there is a systemic, or built-in, variation across a population. By the age of 30, those with the highest levels of education are expected to live four years longer than those with the lowest levels of education

¹ [Equity and endurance: how can we tackle health inequalities this time? | The King's Fund](https://www.kingsfund.org.uk/publications/equity-and-endurance-how-can-we-tackle-health-inequalities-this-time/) ([kingsfund.org.uk](https://www.kingsfund.org.uk))

² Health and Wellbeing in Milton Keynes, 2019: <https://tinyurl.com/58vvd5ta> Accessed April 2022

2 Why we conducted this research

There is, and will continue to be, a big focus on understanding and learning more about what inequalities people experience by the BLMK ICS with the intention to address those inequalities and improve the way health and care services support people who experience greater health inequalities.

Health inequalities are not a novel topic and there has always been a strong moral and economic case for acting to address these. The government and local authorities are now even more dedicated and determined to tackle health inequalities as shown by recent policies, system overhauls and changes in societal attitudes:

- There is a growing resistance to structural racism: the COVID-19 pandemic has seen a growth in intolerance to injustice and renewed a concentrated system-wide focus on health inequalities when it showed that a disproportionate amount of people from ethnic minority backgrounds were more likely to contract COVID-19. This was caused by numerous factors including: deprivation, higher prevalence of comorbidities and led to worse COVID-19 outcomes, occupational risk and delayed access to healthcare³.
- The government is determined to address geographical disparity: the recently published white paper details the approach to 'levelling up'⁴ across the UK. We know that people in lower Socioeconomic groups are more likely to experience severe health inequalities, this does not mean that individuals within these groups experience the same level of health inequalities. Some individuals experience more health inequalities than others no matter what their socioeconomic status because of their individual circumstances and the wider determinants outside of their control. The plan to 'level up' hopes to improve healthy life expectancy and narrow the gap between areas where the gap is the greatest.
- Cross-government reform to tackle health inequalities: Public Health England was closed, and its functions were transferred into

³ [Build Back fairer - the COVID-19 Marmot review \(health.org.uk\)](https://www.health.org.uk/news/articles-and-opinions/build-back-fairer-the-covid-19-marmot-review)

⁴ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1052706/Levelling_Up_WP_HRES.pdf

the UK Health Security Office for Health Improvement and Disparities and NHSE/I⁵. This change aims to ensure there is joined up working across the organisations, and across the country, to address the underlying issues and the wider determinants of health inequalities.

- The new Core20plus5 framework for action across the NHS⁶: this new approach aims to tackle health inequalities by focusing its efforts on the most deprived 20% of the population using indicators accounting for a wide range of social determinants of health (core20). The PLUS part of the framework asks the local Integrated Care System (ICS) to look at its own population to find those groups of people experiencing inequalities but are not necessarily covered in the 'Core'20'. The '5' is added to ensure there is a focus on five key clinical areas:

1. Maternity- focus on women from Black, Asian and minority ethnic communities from the most deprived groups,
2. Severe mental illness (SMI)- ensure 60% of people with SMI receive annual health checks,
3. Chronic respiratory disease- driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations,
4. Early cancer diagnosis- ensuring 75% of cases are diagnosed in early stages 1 or 2 by 2028, and
5. Hypertension case-finding- allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Healthwatch Milton Keynes want to ensure the ICS hear directly from the community about where some of those longer term inequalities in health outcomes might stem from and not make decisions about services based solely on health population data (people as an age, gender, ethnicity, and condition statistic).

⁵ [Public health system reforms: location of Public Health England functions from 1 October - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/public-health-system-reforms-location-of-public-health-england-functions-from-1-october)

⁶ [NHS England » Core20PLUS5 - An approach to reducing health inequalities](https://www.nhs.uk/england/core20plus5/)

Did you know? Health inequalities in action...

- The rate of women dying in the UK in 2016–18 during pregnancy, or up to one year after, pregnancy is more than four times higher for Black women, and almost double for Asian women, than for White women ⁷
- The risk of developing diabetes is up to six times higher in South Asian groups than in white groups⁸
- Deaths from the pandemic among people from ethnic minority backgrounds were two to four times greater than those of the white population ⁵
- 40% of LGBT people report health appointments being postponed or missed during COVID, peaking at around 50% of trans people, compared with 35% of cis people⁹
- People with learning disabilities have 15 to 20 years shorter life expectancy and 38% die from avoidable causes

⁷ [The health of people from ethnic minority groups in England | The King's Fund \(kingsfund.org.uk\)](https://www.kingsfund.org.uk/publications/health-ethnic-minority-groups-england)

⁸ [Risk of Type 2 diabetes in the South Asian community | Diabetes UK](#) ; [2 Public health need and practice | Type 2 diabetes prevention: population and community-level interventions | Guidance | NICE](#)

⁹ [How covid-19 has exacerbated LGBTQ+ health inequalities | The BMJ](#)

3 Methodology

Between July 2021 and March 2022 Healthwatch Milton Keynes have been involved both as hosts and guests at various listening events across Milton Keynes speaking to as many members of public as possible to gather their views and experiences of health inequalities across health and social care service in the town.

We wanted to explore whether people understood what health inequalities are; what health inequalities people experience when trying to access health and social care services and, what would people like to see the health and social care system do to reduce the inequality. We wanted to speak to people in Milton Keynes to understand the specific inequalities they face and how they hinder equal access and patient satisfaction across health and social care service in Milton Keynes and to find out what can be done to improve this to start tackling these health inequalities by feeding back people's feedback to drive policies and guide new health system developments.

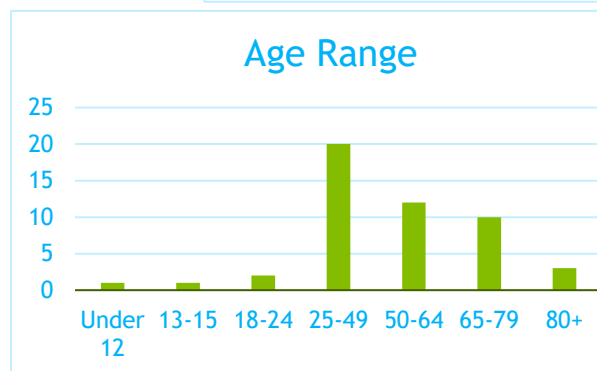
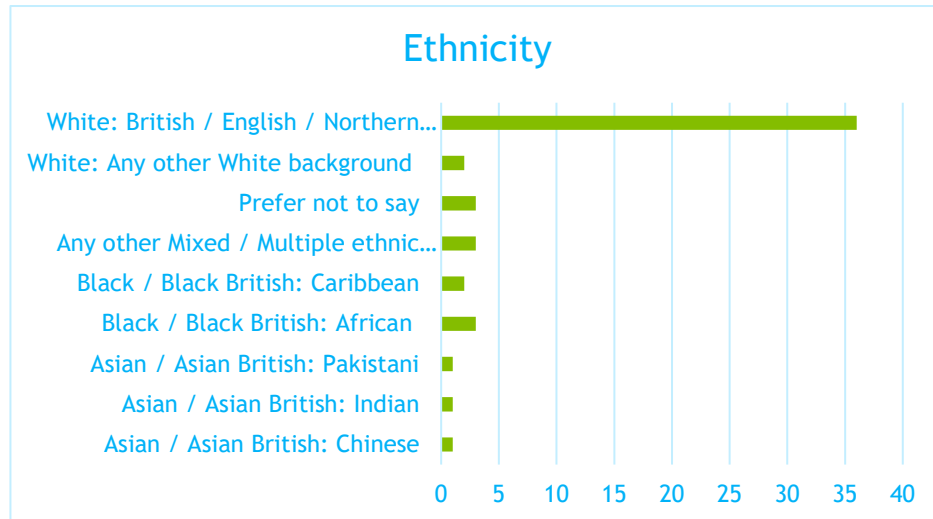
Healthwatch hosted a total of nine events with eight of them taking place between November 2021– March 2022 as face-to-face engagement and held one virtual event in July 2021. Five of these events were involved having one-to-one conversations with people and two were more targeted focus groups. We also held two wellbeing promotion and awareness raising information events. Aiming to bring residents within a community together with health, social care and voluntary sector providers. Through these events Healthwatch Milton Keynes spoke with 128 members of the public to gather their views and experiences of health and social care services and the inequalities people may have faced.

Healthwatch were invited to invited by providers to speak to people at a further ten locations including two supported living facilities, Milton Keynes Urgent Care Service, MK Hospital Children's A&E, two community larders hosted by Parish Councils, two engagement mornings hosted for mum's and babies at the Whitehouse Surgery and two sessions speaking to Rethink service users. At these events Healthwatch Milton Keynes spoke to 437 people to gather their views and experiences of health inequalities and of health and social care services.

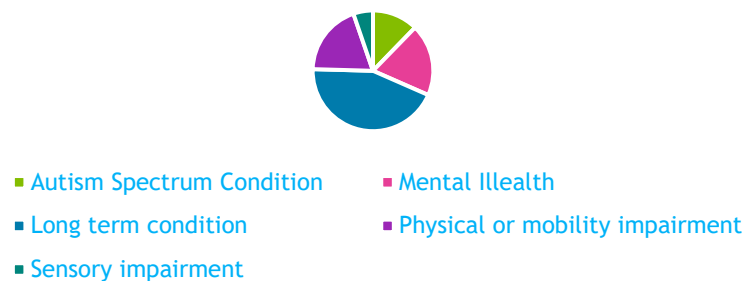
Healthwatch Milton Keynes also ran an online survey seeking feedback about people's experiences of health inequalities when accessing health and social care services. This online survey received a total of 52 responses.

4 Inequalities Survey Demographics

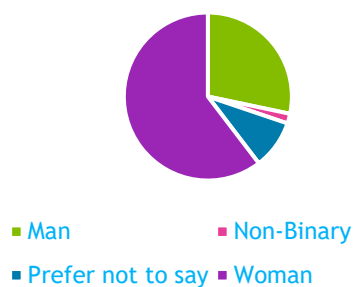
Healthwatch Milton Keynes conducted a survey between November 2021 and March 2022 to explore people's perceptions of inequality. 52 People completed the survey from across Milton Keynes, from Bletchley to Newport Pagnell; Stony Stratford to Wavendon.



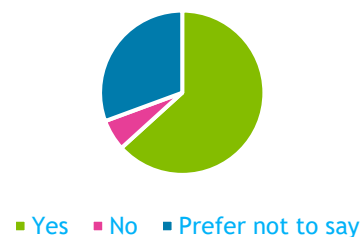
Disability/ Long term condition



Gender (self identified)

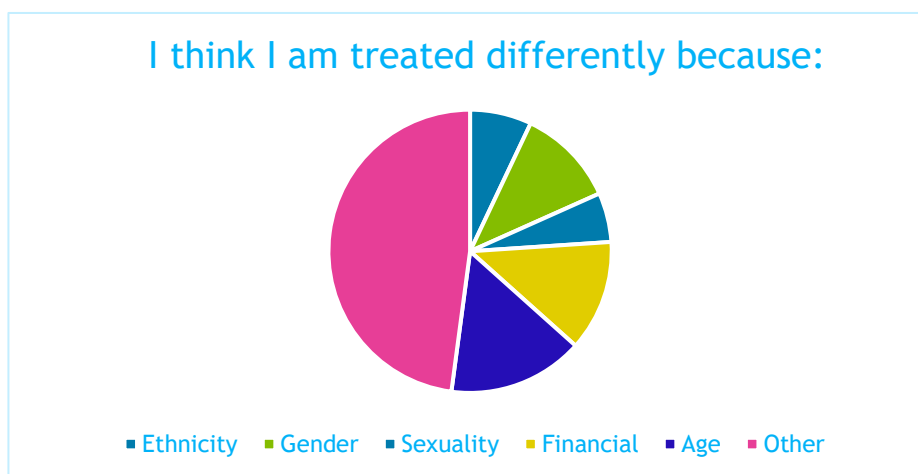


Is your gender identity the same as the sex you were assigned at birth



5 Inequalities Survey Results

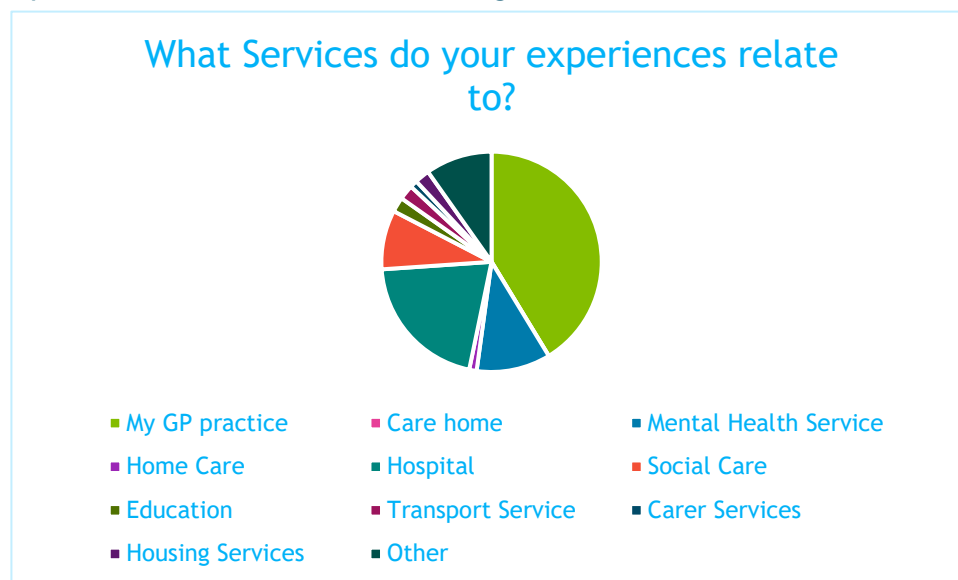
The survey (Appendix 1) was developed to be clear, accessible, and open ended so that people could freely express thoughts, feelings, and ideas about health inequalities they have encountered across health and social care services in Milton Keynes. The introduction set out clear examples of what health inequalities could look like. We used these examples as we have noticed that people's inequalities are so entwined with their daily lives, the issues are not always seen as being an inequality but rather, 'just the way things are'. This was confirmed to us when two respondents chose age or 'other' as the reason they felt they were treated differently, but the example they gave showed that their difficulty with English or accent was the biggest barrier to accessing services. They did not see this as an inequality, just as a normal life experience.



In our survey, of the 33 people who selected 'other' as one of the reasons they felt they were treated differently, 11 said they had Long Term Conditions, 5 reported Mental ill health, and people had 6 Physical Disabilities or Sensory Impairments. There were 13 people who identified themselves as being carers.

Thirty one people selected more than one reason they felt they were being treated differently which highlights the risk, when trying to implement policies and processes to reduce inequality, that policy makers tend to treat each characteristic as a separate and 'free-standing' cause of the inequality. There is an enormous intersectionality across the root causes of inequality, and these must be looked at as a whole in order to target solutions effectively at root causes and not on the symptoms.

Healthwatch Milton Keynes agrees with the Commission on Race and Ethnic Disparities when they suggested that the use of, such as ‘white privilege’, or imprecise ones like ‘BAME’, can be seen as unhelpful, stigmatising and potentially divisive as they have the unintended consequence of pitting groups against each other.¹⁰ It also allows for correlation to be seen as causation, for example: the disproportionately high rate of maternal deaths in Black women becomes a form of ‘victim blaming’ because it implies that the higher rate of death is *because* they are black. There are no biological differences between women of any ethnicity that should cause this disparity. When we recognise and acknowledge this, it means that a much more difficult conversation is required to find out what is actually causing this group of women to die in these higher numbers.



When we asked people where they felt they were being treated poorly because of their personal characteristics, only 4 people selected just one service. Those four people selected their GP practice where getting an appointment was the first issue they raised, but three of those four people felt that their GP was dismissive or was not listening to their concerns because of their age, gender, and/ or mental health condition.

Those people who selected ‘Other’ described unhelpful criteria, policies, or assumptions preventing access to services provided by specific departments of the Hospital, Voluntary or charity organisations, and Social Care.

¹⁰ <https://www.gov.uk/government/publications/inclusive-britain-action-plan-government-response-to-the-commission-on-race-and-ethnic-disparities/inclusive-britain-government-response-to-the-commission-on-race-and-ethnic-disparities>

6 Common experience of inequality

When the survey results are combined with what residents across Milton Keynes told us about their experiences, there are clear commonalities across groups. The exact nature of the barriers and difficulties are specific to individuals or cohorts, but the overall experience, and resulting inequality, are the same.

Common experiences of inequalities	Who told us this
Having to have several appointments with a GP to receive the right diagnosis, treatment and care because of language barriers, having a strong accent.	Both men and women and people from Black, Asian, and Eastern European backgrounds. People with sensory impairments.
Experiences of feeling judged, or having health and wellbeing experiences and needs being dismissed as mental health issues, or stemming from autism	Trans people, people with existing mental health issues and/or autism. People from both Black and White backgrounds.
Experiences of challenges in being listened to by health professionals as an expert of their own body, receiving correct diagnosis and support	Trans people, women with Gynaecological problems. People from both Black and White backgrounds.
Challenges receiving the right assessments and support	People with SEN, ADHD, autism, carers and people with Mental Health. People from Black and White backgrounds, and people who were excluded by age or financial circumstances.
Poverty impacts on access to health services (transport), healthy food and dental care	Women from Black and White backgrounds. People on low incomes.
Difficulty in getting the right information and advice from healthcare professionals	Women of all backgrounds, ages, maternity/ perinatal/ puberty/ fertility/ menopause Trans people,

7 In their own words:

GPs need to be more thorough in their assessments. Carry out tests and examinations, rather than have you coming back 2-3 times – Somali Woman

Should have been flagged earlier, things should be detected better, Delay in referrals being made- no SEN support for son- White British Woman, Carer

Someone who could talk to you properly a caring person to delve deeper. Never had a real diagnosis- – specialist therapies team psychiatrist never explained anything just prescribed medication – White British woman, 65-79, Mental ill-health

Being told my super painful periods "aren't anything to worry about, it's just how women's bodies work". Being told that when, in my 40's when my hair started thinning, my vagina started being less flexible and my periods became irregular, I was "too young to think about perimenopause". Being told that my anxiety and PTSD were just me needing to meditate more. Constantly going through the question loop of "are you married?" Yes. "Are you trying for children?" No. Are you using birth control? No. "... "I'm still in a same sex marriage, remember? We talked about this last time and you put it in my notes?" It's always awkward. They never remember. And sometimes with new ones you can tell they really don't approve. – White British Woman, LGBTQI+

Given my various ongoing health issues I would have expected to be offered a call with someone to be able to discuss my concerns. Every appointment I request is denied, regardless of the reason.- Person with Autism and Mental ill health

Based on my symptoms alone I should be treated. Nobody should be expected to endure this level of pain on a 4 weekly cycle with no offer of treatment. The cysts, polyps and endometriosis should further cement the need for treatment. – White British Woman

Not brush people off. Respond when referrals result in requests for medication changes or more information: White British woman/ Mental ill health

They should have asked me about what my current condition is, how severe my symptoms are etc. They tend to think people of colour (ethnic minority) will leave it and won't complain so it is always easy to turn us away when we try to make an appointment. – Chinese man

Mental health issue when parents separated, councillor refused to listen and insisted my issue stemmed from "being trans". Second attempt to obtain mental health aid I was asked to go to a religious based therapy group rather than a councillor – White British Woman, LGBTQI+

Had ongoing chest problems and GP wouldn't send for x ray. They gave me antibiotics twice and they didn't work. I complained for a long time about my chest and went to the A&E for a month and a half until I was sent for an x ray. They don't listen to you, I didn't feel listened to or that my condition was treated with the proper urgency or examinations as needed. It takes 30+ tries to get through to speak to a GP – it shouldn't be this hard! Only for them not to treat you properly – Black British/African Man

Staff need to be aware that not every disability is visible. All clients should be treated with the same respect – Black British/Caribbean Woman

I was told by a receptionist I do not need to speak to a GP about my increasing anxiety or bipolar, that she would ask the GP to adjust my medications (no appointment booked). – White British woman, Mental ill health

I have had some health issues, my GP didn't check me physical and prescribed medicine over the phone. Problem didn't solve even after medicine and I have lost weight. Again, they sent me hospital and I have been checked by doctor and prescribed different issue then they gave me medicine for – Pakistani Woman

People from low income jobs tend to have less flexibility when it comes to requesting time off from work. It makes attending a GP appointment more difficult. – White British Woman, Long Term Condition

I can't access any further treatment because I can't get to my doctor to see them because of my job. I don't have any more money to do any more. – White British Woman, Long Term Condition

I am a young trans man and the lack of support, knowledge and care for people like me is destructive. My GP said it's a phase, my school force me to use the women toilets and CAMHS are saying it's all because I'm autistic. – White British Man, LGBTQI+

Over the past 10-15 years, I have routinely complained of various issues which I believe are connected. I have been told I have had early menopause, which was underactive thyroid. I was told I had IBS which was coeliac disease. Instead of looking for the cause, I was told that it was the anxiety causing the problems. I paid for a private blood test which shows I have high testosterone levels. A sign of polycystic ovaries but also a cause of anxiety, depression, fatigue. Why hasn't this test been done by my doctor instead on fobbing me off? I should have been treated for this a long time ago, instead of still trying to get someone to listen to me. – White British Woman, Long term Condition

I was laughed at and outed to strangers about my transgender status at the hospital. I regularly find it difficult to get to my local health services because I have limited mobility but need to attend regularly. I have been dismissed by GPs and mental health professionals over significant symptoms when I was a teenage girl (so age and gender factors). As an autistic adult I have found it very difficult to get GPs to believe my lived experience and have had to return to ask again about the same symptoms year after year, and never received a firm diagnosis – White British Non Binary, LGBTQI+/ Physical Impairment

I'm writing on behalf of my son who is 8 years old, and has non-verbal autism and severe learning disability. His school phoned me to ask me to take him to hospital because they thought he was unwell. I took him to Children's A&E, a nurse came out and told us that this wasn't a suitable place for him, and that he didn't look like he needed to be seen urgently and told me to book him a GP appointment in the morning. The GP told us he needed bloods taken, so we took him to the practice nurse. As soon as she saw him, she said that if things got difficult, she would just refuse to take his blood. – British Woman, Carer

There shouldn't be an age limit, can't say because I haven't reached that age, I shouldn't have that need- I need a new knee can't have new knee until I'm 55. I need aids put in place – cant unless I pay as I am not old enough, so can't get them because I can't afford to pay – White British Woman, Physical Impairment

8 What would help?

We asked people to tell us, when thinking about their experience, what should have happened, or what the service could have done differently.

- *Having multilingual speakers to answer phone calls*

As always, people suggested that better, or more appropriate, communication would make the biggest difference to them. While this might be difficult to manage, ensuring that staff know how to access the language services would be a quick way to reduce this particular inequality.

- *Staff need to have some awareness training. Diversity and inclusion training*

This need was expressed by people from backgrounds other than White British, by people who identified as LGBTQI+, and by those living with a neurodiverse condition. No-one we spoke to expected that every person would be an expert in every difference. The expectation is, instead, that all staff would be aware that 'I treat everyone the same' does not equate to 'I make sure everyone has the same good experience'

- *refer or support people with issues rather than dismissing until they're more 'serious'.*
- *GPs to have more time to take a holistic view of someone's health - They only have time to address a single symptom and there have never been GPs proactively trying to see the full picture*
- *Don't just give leaflets, there needs to be support that gives inspiration, motivation, guidance*
- *Someone who could talk to you properly a caring person to delve deeper- nice to have someone realise that, for me- quiet one in the back*
- *Making sure that staff look at my file and noter I am hard of hearing before insisting I have a telephone consultation. Make sure I have another option apart from a phone call to make an appointment.*

The underlying theme here is that people want to feel they are being taken seriously, that someone cares about them enough to help them get well. This is likely to require a cultural change which public facing staff will find very difficult as the system pushes them to see more people in as we move into the 'Restore' phase of the pandemic. While GPs may not be able to offer longer than 10 minute appointments at this stage, making full use of the Additional Roles Reimbursement Scheme (ARRS) posts such as the Social Prescribers may be, in many cases, a step in the right direction. Time needs to be spent making sure that the social prescriber is aware of the many services on offer in the area and is able to offer appropriate support to encourage take up.

The inclusion and diversity awareness may be of use for practitioners in order to avoid diagnostic overshadowing based on preconceived ideas, or any unconscious bias, that might impact on the patient's care and treatment.

9 Recommendations

- **Ensure that every patient or service user is asked about, or offered, the support they will require to be able to understand the information being given to them.**

This is required under the Accessible Information Standards¹¹ and the Equality Act 2020. Whilst not being able to speak English is not a 'protected characteristic' defined under the Equality Act 2010, section 13G of the National Health Service Act 2006 ("NHS Act") states that NHS England, 'in the exercise of its functions, must have regard to the need to reduce inequalities between patients with respect to:

- Their ability to access health services; and
- The outcomes achieved for them by the provision of health services.¹²

Commissioners may need to consider how these services are procured across the BLMK area, or how they are written in to service specifications to ensure they are being provided by commissioned services.

Consider the way that a patient's need for reasonable adjustments can be shared at the point of referral or discharge. The current practice causes common inequality reported by people with hearing impairments or languages other than spoken English.

- **Consistent BLMK wide Inclusion and Diversity Awareness training should be part of the induction for all new staff, with regular refresher training to ensure that best practice is maintained.**

- **Address the issue of diagnostic overshadowing and ensure approaches to improve person-centred, holistic care is a focus for BLMK Integrated Care System leaders.**

We would recommend further research is done locally with core groups of patients affected by diagnostic overshadowing to establish the extent and to support the system to develop a practical approach to reducing the prevalence.

¹¹ <https://www.england.nhs.uk/wp-content/uploads/2017/08/accessible-info-specification-v1-1.pdf>

¹² <https://www.england.nhs.uk/wp-content/uploads/2018/09/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care.pdf>

10 Appendix 1– Inequalities Survey

Your experience of care

Healthwatch Milton Keynes is your local health and social care champion. We're also a statutory body and an independent charity. We listen to the experiences shared by people who use health and social care services in Milton Keynes and tell the people who provide your care what they do well, or what they need to do better. If you use GPs and hospitals, dentists, pharmacies, care homes or other publicly funded support services in your area, we want to hear about your experiences. We have the power to make sure NHS leaders and other decision makers listen to local people's feedback and improve standards of care.

We will ask for information about you such as your gender identity, ethnicity, and age. This helps us to understand if any particular groups of people are experiencing inequalities more, or differently than others. Anything you tell us will be published in a thematic report and any personal identifiable details about you, as an individual, will remain anonymous. Your individual circumstances will not be recognisable unless you consent to it, and we will ask you about consent at the end of this survey. If you would like to know more about how we manage your personal data, visit –www.healthwatchmiltonkeynes.co.uk/privacy.

What does health inequality mean to you? Have you ever felt that you've been treated unfairly?

Some health inequalities look like this:

- I feel my concerns about my health aren't taken seriously and are dismissed as 'women's problems'.
- I want to feed my children healthy meals but fruit and veg is pricey, and I'm often reliant on food banks or donations.
- I don't speak good English and need a translator.
- I'd like to go for a walk or a run but don't feel safe.
- I must catch a bus if I want to get to a doctor's appointment, and I can't afford the bus fare.

- Our flat is damp and the landlord won't help. It's making my son's asthma worse.
- My daughter needs to get to her hospital appointments, but we don't have a car and the bus stop is miles away.

These are all examples of health inequalities. If you feel you've not been treated fairly because of where you live, the cost of living, your age, ethnicity, gender, or your sexuality for example, then that is an inequality and you're not being treated fairly.

Do you feel you might have experienced health inequality by not having access to healthcare and/ or receiving unfair or unequal treatment when accessing health or social care services in Milton Keynes?

What was your experience?

Which service was it?

E.g., GP Practice, Care Home, Mental Health Service, Domiciliary Care (you can list multiple services)

When thinking about your experience, what do you think should've happened instead?

Is there anything else you think the service(s) could do to improve people's experiences?

Is there is anything else (positive/ negative) you've not told us already that you'd like to share about health or social care services you've used?

Please complete the additional questions about you, as a person. This information will help us to better understand if any particular groups in Milton Keynes are being disadvantaged.

Your GP Practice:	
-------------------	--

Your age:	
Your gender:	
Your ethnicity:	
Do you consider yourself to have a disability?	
Do you have a long-term condition?	
Are you a carer?	
How often do you need to contact your GP practice?	

Consent

I consent to Healthwatch Milton Keynes using the information in my response today in a published report but wish to maintain anonymity

I consent to Healthwatch Milton Keynes using the information in my response today in a published report and Healthwatch Milton Keynes can use my personal information for case studies or quotes in their report. I understand that this may make me identifiable as an individual.