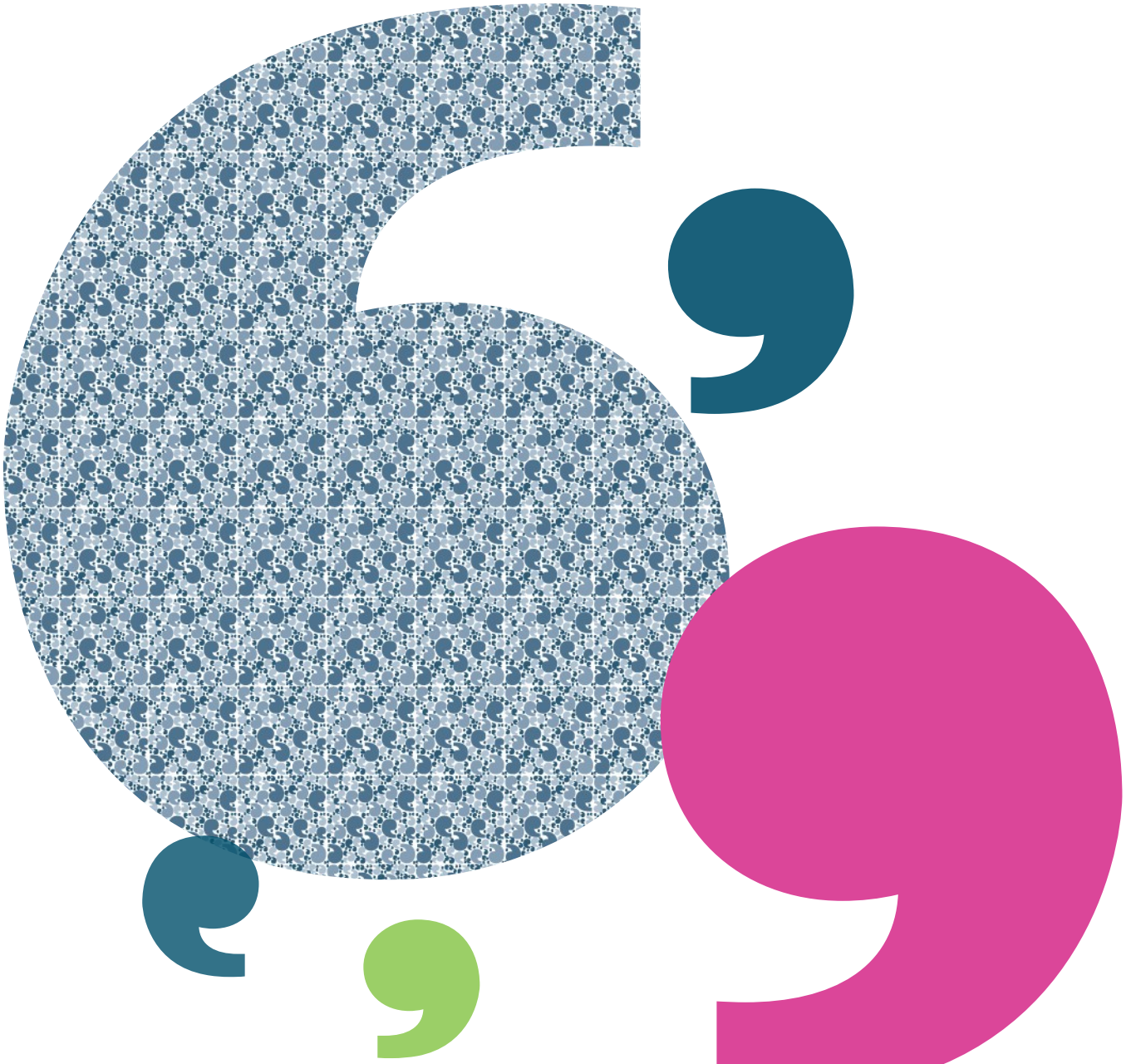
healthwatch Ealing

'Local voices improving local health and social care services'



Healthwatch Ealing

Somali Health and Wellbeing

Specialist Report March 2016

Acknowledgements

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In partnership with:

DeFacto Total Consultancy
Horn of Africa Disability and Elders Association
Barwaqa Relief Organisation
Education and Skills Development Group
Good Effort for Health and Well-Being.

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Sharmarke Diriye—DeFacto Total Consultancy

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Mr Mohamed—Education and Skills Development Group

Hussein Dima—Barwaqa Relief Organisation

Abdi Ali—Southall Womens Group

Sagal Osman- Good Effort for Health and Well-being.

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Introduction

Introduction to Healthwatch Ealing

Healthwatch Ealing is the independent consumer champion for the public to promote better outcomes in health and social care for all in Ealing. Whether it's improving them today or helping to shape them for tomorrow. We are all about local voices being used to influence the delivery and design of our health and social care services. We have a statutory right to be listened to by commissioners and providers of services.

Our role is to argue for the consumer interest of all those who use health and social care services. Our starting point is people's experiences, needs and wants and we base our work on solid evidence and intelligent analysis. We work with individuals and organisations including voluntary and community groups to help build a local, regional and national picture of trends and issues that matter most to the people.

Our role is to state where changes are most needed and also be realistic in such way from a view point of a 'critical friend' with a pragmatic view.

We use the evidence we gather to identify local and national trends and issues, and to influence national policy. We advise the Health and Wellbeing Board, Overview and Scrutiny Committees, Secretary of State for Health, Monitor, NHS England, Ealing Clinical Commissioning Group and London Borough of Ealing about our findings and report to Department of Health every year.

Purpose

Healthwatch Ealing conducted outreach events for Somalis living in Ealing community via Horn of Africa Disability and Elders Association (HADEA) drop in session.

Somali organisations have long made the case for health and social care needs of the community. Through Healthwatch an opportunity arose, for the first time, to make a case for the entire community's health and social care needs and wants - specifically for the benefit and attention of major decision makers.

The representatives of the Somali community said there were not enough Somali community groups to care for them in the borough. This was particularly noted by those whom English was not their first language and were not familiar with the NHS and social care support services delivered in the borough.

Working collaboratively with Somali support organisations, Healthwatch Ealing undertook this project to identify how and whether the issue raised, had an impact on the access of the Somali community to health and social care services in Ealing.

The aim of this work is to share our findings with service providers and commissioners of health and social care services. To enable them to increase their understanding of the needs and experiences of the Somali community, which we hope will inform their policy and planning , to reduce inequalities amongst ethnic minority such as the Somali community.

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Executive Summary

Healthwatch Ealing has a role in gathering patient experiences in the community which give a picture of strengths and gaps in local services. We have built continuing links with Somali community organisations and recurring issues were being raised through outreach work for Somali people living in Ealing.

A scoping exercise was undertaken to map existing services and identify active Somali community groups. From this it was noted that a large number of Somali organisations had closed down since 2008.

Part of the scoping exercise included looking at the specific Somali services provided by different organisations. The Somali organisations were providing support and advocacy in 3 main areas, housing, health and employment. We found direct feedback from the community on these three areas highlighted that these are the biggest issues facing Somalis in Ealing. We identified numerous accounts of the difficulty of engaging with GPs, uninhabitable living conditions and lack of visible support systems for Somalis.

Following the scoping exercise Healthwatch considered there was enough evidence to initiate an engagement project to gain further views from Somali people living in Ealing and those who work directly with them in support services. As a result of the scoping exercise, members of Somali support services formed a focus group and agreed to support Healthwatch Ealing to conduct community research with Somalis living in Ealing.

Healthwatch Ealing noted members of the community that we approached through the support of Somali support services were more willing to provide feedback on their needs and experiences, this contrasted with when we approached members of the community as individuals in outreach activities. This is an affirmation that Somali community organisations offer conducive environments for Somali users to freely discuss and share their health and social care needs and concerns.

From the survey and as a result of direct feedback from Somali support services, we found there were Somali individuals with complex care needs living in Ealing. It became clear that many of these individuals were not familiar with the health and social care services available to them. Isolation, language barriers, co-morbidity with other health conditions and poverty were evident. Gaps in care for these individuals were identified and Somali support services felt more specialist community support was needed which they felt could be funded by Ealing council.

Looking at the particular needs of elderly Somalis in the borough of Ealing, those living alone often felt isolated. The general assumption is that the Somali community is a tight-knit community. However, it was highlighted there is a need for specialist support to manage the emotional impact of diagnosis and medical advice and care amongst lone elderly Somalis, who do not have a good command of the English language. These individuals often found self-care management difficult even after consultations with GPs and other health professionals.

Healthwatch Ealing has highlighted a gap in the care of Somalis living in Ealing and recommends that the local and national commissioners of health and social care services review the current health and wellbeing support available to the Somali community, taking into consideration the findings of this report.

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Scoping the Issue

Background

In the 2011 census the Ealing borough *(Ealing JSNA, 2014)* , located in West London was home to 338,449 people. It is London's third largest borough by population *(Census 2001)*.Ealing is a very diverse borough.

The school population in Ealing maintain a high level of ethnic diversity. In recent analysis the increase has furthered *(School Census 2011)* :The biggest growth continues amongst the Somali population, There are now 4,299 Somali pupils (an increase of 213 in the last year and 1,215 in last five years). *(Ealing Children and Young People Plan 2011-2014)*

According to the January 2014 School Census, the percentage of pupils in Ealing schools whose first language was English was 35.2% in primary school and 46.1% in high school. Pupils in Ealing schools speak over 100 different languages and the most common language spoken after English is Somali *(Spring School Census 2014)*.

Attainment of specific pupil groups

In 2011 the average performance in both Key Stage 1 and Key Stage 2 Somali boys were amongst the lowest performing in the borough. The data shows that boys continue to perform significantly below the borough average at all key stages. In particular, in 2011 across all key stages pupils who are entitled to free school meals continued to perform significantly below the borough average. Black heritage pupils, in particular Somali pupils continue to perform below the borough average at the end of primary and high school. *(Ealing Children and Young People Plan 2011-2014)*

A key indicator of deprivation levels is Free School Meals (FSM). The average figure nationally in primary and high schools is 17% and 14%, respectively. In Ealing, these figures are much higher at 23% and 26%, respectively *(School Census 2011)*. This clearly reflects there are a larger number of pupils from low-income families in Ealing schools, particularly at high school, where entitlement to FSM is nearly double the national level.

Scoping the stakeholders

Healthwatch Ealing aims to capture the voices of all communities living in Ealing. For a very long time the Somali community in Ealing have been defined as a 'hard to reach' community. Hamdi Issa, the Strategic Engagement Officer, and fluent in Somali began an outreach project that spanned between June 2015 and November 2015 reaching out to existing services and documenting the main issues arising in the Somali community of Ealing.

From attending the drop-in centres an issue became apparent in the Somali community. The health of these residents was being exacerbated by their living conditions. Poor insulation and dampness leading to physiological stress in the elderly and increased risk of respiratory illness in young children were common complaints.

Therefore, for the first time ever, Healthwatch Ealing decided to undertake a project to highlight issues relating to the health and wellbeing of the Somali community in Ealing. With a view to producing a report that would have the potential to inform the work of the Ealing Council, Ealing Clinical Commissioning Group, voluntary and third sector organisations and other relevant stakeholders regarding the Somali community.

As Healthwatch Ealing was unfamiliar with the exact number of Somali organisations that existed and where they operated across Ealing, Hamdi Issa used online resources and the databases of Ealing Community and Voluntary Service (ECVS) and Ealing Community Network (ECN) to map the location and reach of existing services. From this research it became apparent, that many organisations were no longer listed. In order to find the active groups, Sharmarke Diriye an independent consultant that works within the Somali community, helped Healthwatch Ealing to identify and connect with the active Somali organisations.

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Gathering experiences

Methodology

Community Research
As Healthwatch is a consumer champion organisation that gathers the views and experiences of patients, service users and the public we needed to hear from Somalis living and working in Ealing. We sent out an involvement opportunity requesting involvement of Somali organisations in Ealing to contribute to a community research project to plan and design a method of gathering feedback from the Somali Community in Ealing. Sharmarke Diriye used his contacts to reach out to various organisations.

Planning the method

In the first instance 5 project coordinators attended a focus group facilitated by Hamdi Issa and Sharmarke Diriye. In this session the remit of Healthwatch Ealing was explained to the representatives and the project proposal was outlined.
The proposal was to ask the Somali project coordinators to act as channels through which Healthwatch Ealing could gain feedback from the members of the Somali community about their knowledge and experiences of health and social care services.
Then Hamdi, Sharmarke and the project coordinators worked on the logistics of how Healthwatch Ealing should gather responses. Hamdi Issa piloted a questionnaire that would be used to direct the focus group sessions of the individual groups.
The project coordinators had the opportunity to feedback on the feasibility and appropriateness of these questions before a final version was drafted to be used by each organisation.

Somali Organisations who engaged with the project

Ayan Keynan – Women and Child Development Organisation
Hussein Dima – Barwaqa Relief Organisation
Muktar Handule & Ali Elmi - Golden Opportunity Youth Association (GOYA)
Yusuf Guled – Horn of Africa Disability and Elderly Association (HADEA)

Didn't attend session but contributed to project

Abdi Ali – Organised Southall women's group
Mr Mohamed – Education and Skills Development Group
Sagal Osman—Good Effort for Health and Well-Being

Developing a Questionnaire

A questionnaire was developed which included closed questions, open questions and a space for 'case studies' highlighting the Somali community's experiences of health and social care services.

Questionnaire results were drawn from both the Somali organisation service users and the service providers to build a wholes picture of both the health and social care needs and barriers to access for the Somali community in Ealing.

The questionnaire was used to capture the change in services since 2008, (when a large number of Somali organisations shut down) and how the remaining organisations are coping with this increased demand in the number of service users to staff members, services provided, funding and establishment, as well as the issues that are impacting on the members of the community.

A copy of the questionnaire is attached to this document. See Appendix A.

Additionally, a questionnaire was developed to understand the services these community groups are providing. 2 Somali organisations responded. See Appendix B.

Gathering Responses

All members of the Somali support services agreed to hold mini focus groups in their own offices. Two project coordinators decided to invite Hamdi Issa to their focus group sessions to help facilitate the conversations. A third, and new project coordinator approached Hamdi Issa to attend a focus group and speak to service users to gather responses herself. Some of the project coordinators translated the questionnaire into Somali to allow the service users, predominantly older women, to have a better understanding of the questions being asked. Subsequently they emailed their responses. The final project coordinator undertook the questionnaire through their 1:1 sessions and returned the questionnaires by hand. **3** visits were made to Ealing Hospital were Hamdi Issa gathered data from Somalis using the hospital services.

Case studies

Each Somali organisation was given the opportunity to feedback one or two individual case studies they thought best captured the health and wellbeing challenges of the wider Somali community in Ealing.

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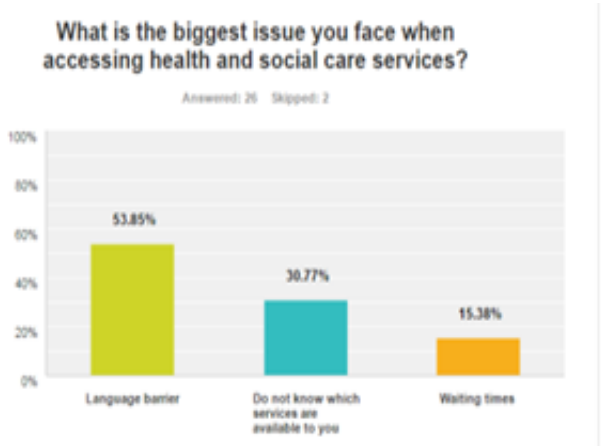
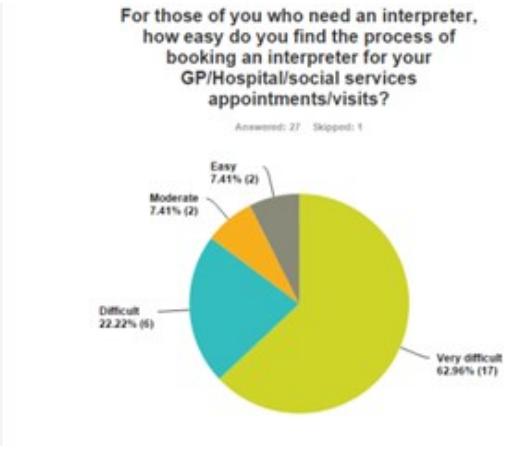
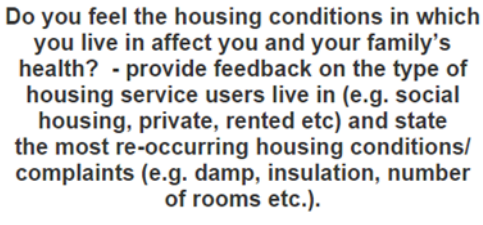
Survey results summary



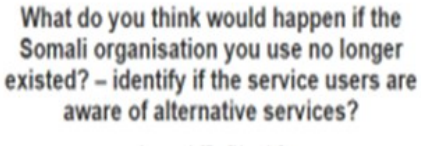
More than half the respondents found language barrier as the biggest access barrier.



Almost 63% of respondents rated the ease of booking an interpreter for medical appointments as very difficult.

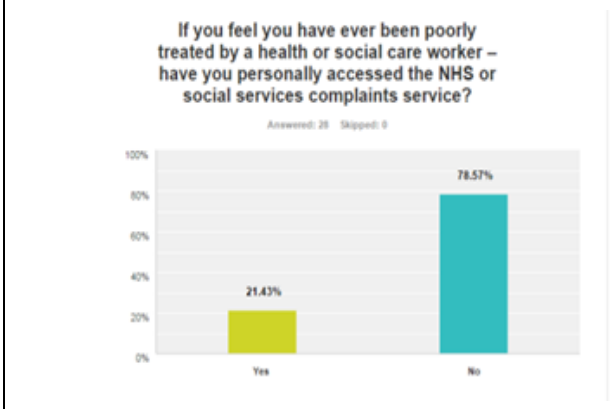
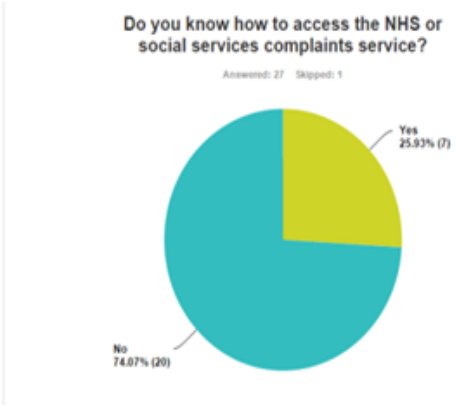
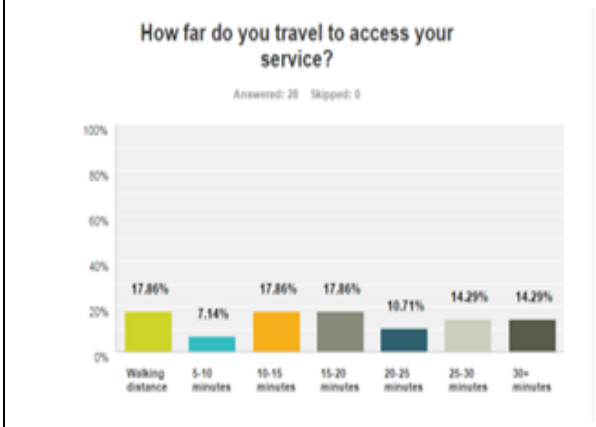
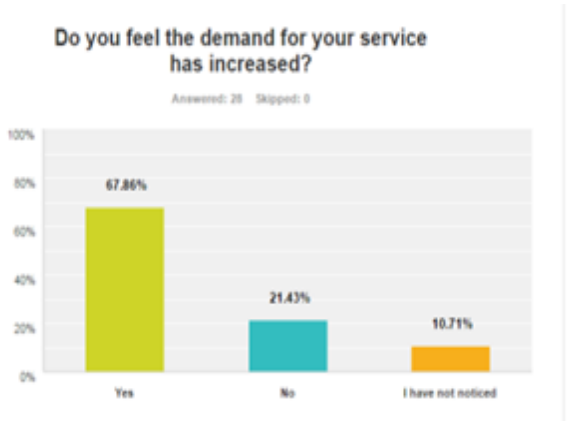


The majority of respondents had an issue with damp, overcrowding where they felt such harsh environments made often their youngest children unwell, frequently.



The greatest share of the respondents felt closure of these organisations would have detrimental effects on the community. Not a single respondent could identify an alternative service.

Do you have to wait for longer periods of time to have your issues dealt with now? (Following the closure of multiple Somali organisations in Ealing since 2008).
71% of respondents stated they often have to wait longer periods of time to see someone.

	
Almost 80% of respondents said they have never accessed the NHS/social care complain service despite being poorly treated.	74% of respondents said they do not know how to access the NHS/Social care complaint services.
	
When respondents were asked about the distance they travelled to use their services, all time groups were represented and most represented similar number of respondents.	67% of respondents felt the demand for their service has increased.

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Direct Feedback

Whilst undertaking this project we made contact with a number of support workers, and service users. Many of these were able to give direct feedback on the experiences of Somalis living in Ealing and the barriers to health and social care access they are facing.

A lot of people using Somali support services do not speak English. That is why the need for these groups is so great. But in recent years, with funding cuts, many are disappearing. Ealing council needs to understand the importance of these groups for reducing the inequalities faced by our community. **—Service User, West Ealing.**

You know, if Somali organisations did not exist I don't think I would be here. My health has been deteriorating for many years and it is only through the support of these organisations was I able to understand the care available to me.—**Service User, Southall.**

We have a huge barrier between Somalis living in Ealing and health care professionals. The language gap and lack of access to adequate interpreters makes many Somali residents feel like '2nd class citizens'. That they are being short changed for their misfortune of not understanding the English language. **- Support Worker, Northolt.**

For 9 years I have taken over 4000 Somali women, many from Ealing to FGM clinics. I act as an interpreter, advocate and emotional support. For 9 years I have not received any financial assistance for my organisations work, despite the number of accolades I have collected to acknowledge how pivotal our work is. **- Sagal Osman, Good Effort for Health and Well-Being.**

Our voices are absent. Our GPs do not listen to us. The Council does not hear us. Then all of a sudden the organisations that were supporting us were being forced to shut down because the Council wont support them. I thought Ealing was about inclusivity. Well I will tell you something, most Somalis in Ealing do not feel included right now.—**Service User, Northolt**

We have an elderly gentleman that has had surgery on him twice, without knowing why. He can barely communicate with his GP and all these healthcare professionals are poking at him, cutting him up without ensuring he is fully aware of the procedure, the possible risks and the appropriate aftercare. - **Support Worker, Ealing.**

We have a mother raising 3 kids, one of whom is disabled. She has spent many months asking to be rehoused because her current living conditions are too cramped for her and her 3 children. Additionally, she needs space to put in medical equipment that will supplement her daughter's physiotherapy sessions. Her physiotherapist has assessed her house and concluded the family need new spacious accommodation. The housing association are not taking her concerns seriously. And her own GP will not support her in her claim by writing a letter to explain her daughters medical condition. When professionals fail to work together to provide holistic care to vulnerable members of our community, often many Somalis feel isolated. - **Support Worker, Southall.**

Direct Feedback

Since the welfare reforms and changes in disability related benefits the community has been struggling to reconcile the changes of their entitlement to such benefits. Before the changes all you needed to do was fill in a form and medical history . Now, you have to complete a work capacity assessment which disadvantages those with a language barrier, because of the great difficulty that many have in explaining their condition. This has shown an increase in the number of Somali disabled patients having their benefit wrongly refused. **- Support Worker, Ealing**

Prior to 2014, no Somali community group has been funded to deliver health and social care focused projects. **- Support Worker, Ealing**

Somali groups have a history of running Health and Social care focused projects - for the past 20 years or so - and the best example is the Refugee Health Advocacy set of projects initiated by the NHS in the 1990s and delivered by a number of Somali organisations in Ealing. **- Support Worker, Southall**

Very soon and supported by myself, a vibrant and unique Somali-run Pharmacy will open in Hanwell - where community based health services will be provided and where Somali groups will be offered space and platform to run their health and social care focused projects. When this opens, the council and ECCG should be ready to engage with the team and support them to create a space promoting health and social care.—**Support Worker, Ealing**

We have deaf or hard of hearing Somali, mainly women using our services. Often there is a communication gap between the women and the signers they are assigned for medical appointments. These signers are 'high-level' signers. But the women have often not attended school in either their birth country or the UK so they cannot read, write or understand English. So access to these high level interpreters is not useful to a group that cannot understand BSL. There needs to be greater funding of BSL lessons to support these groups that cannot sign using BSL. -**Support Worker, Ealing.**

Diabetes and high blood pressure is a big problem in the Somali community, something we have inherited with the western lifestyle. So many Somalis, usually the elderly, do not know how to manage their condition. I feel healthy lifestyle sessions delivered in Somali, in their homes, teaching them how to cook, or taking them out for walks is beneficial for this community. Many of us can provide such service, but we are not supported to do so. The council need to engage with the community more.— **Support Worker, Ealing.**

We need more funding. We, all Somali groups that have remained, collectively see thousands of Somalis a month. The demand is great but our resources are limited. The council and such like bodies are not taking us seriously. For us to provide the best service possible for our community, we need more financial help from the council. They too should be concerned about solutions to better meeting the needs of the Somali community in Ealing.—**Support Worker, Southall.**

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Case Studies

Case Study A

Issue: Health literacy

'A' is an elderly woman, living alone and presenting with multiple comorbidities. 'A' does not have a very good command of the English language, although she is able to mildly express her pains, she struggles to understand her GPs comments. 'A' visited her local GP in May 2015, a surgery she frequents. When she can, she takes her grandchildren as interpreters, but often they are busy with school. On this occasion , 'A' went alone to her consultation.

After telling the GP her symptoms she was prescribed medication. When 'A' returned home from the GP and pharmacy, her granddaughter looked at her medication and noticed it failed to illustrate how often to take the dosage and directions for use. Instead the medication had a label that read 'follow the doctor's instructions'. 'A' struggled to recall what her GP said during her consultation.

This is not the first time she has picked up medication without instructions. Therefore, on numerous occasions she has either overdosed or missed time slots to take medication. 'A' travels to Somali support services to get help to explain to her how she is supposed to use her medication.

Often patients use Somali services to help them translate directions of use. But these services are not in the position to or understand what 'per doctor's directions' means. Although they can advice is for patients to go back to their GP/pharmacist and have a new label printed.

Unfortunately, many Somali patients with the most complicated health care problems are at greatest risk of misunderstanding their diagnoses, medications and instructions on self-care.

Case Study B

Issue: GP – Patient Engagement

A woman came to a support service in West Ealing to receive advocacy after her GP refused to take note of her requests. Her daughter had an operation on her spleen at the age of 2. Frequently, her daughter gets nauseous and sick. This is also putting a toil on the other children because the family live in an overcrowded house. So at night when the mother comes in to assist her daughter the noise and lights in the house disrupt the other children's sleep.

For 3 years the mother has been asking the GP to refer her daughter to a specialist since the GP could not identify the reason behind the child's continual sickness. When the mother contacted her local Somali support service the coordinators relayed all this information in a letter and requested specialist referral for the woman's daughter. The project coordinators note, upon receipt the GP immediately referred the child to a specialist. When the specialist saw the child, he was shocked she had not received the specialist consultation she was entitled to every year. The mother was distraught that her daughter missed out on specialist care for 3 years. The organisational leads feel it is distressing that an intervention by their organisation is required for GPs to listen to the needs of Somali patients.

In a separate case, to highlight this deficiency further, Sagal who supports women victims of FGM vocalised her concerns over lack of GP support for Somali women. Often these women suffer from supplementary gynecological issues such as cysts and fibroids. Once the specialist FGM consultant deals with the FGM issue they inform the patients they need to go to their GP to seek a hospital referral for their cysts and fibroids. On numerous occasions Sagal notes GPs have ignored the plight of these women and informing them such referral is not necessary, despite hospital clinicians telling the women otherwise. This mixed messaging has forced hundreds of women to go abroad to receive medical treatment and surgical procedures.

Case Studies

Case Study C

Issue: Disjointed care

A lady with 4 children all under the age of 10 lives in a 1 bedroom flat. Her youngest child, of 3 years old, is suffering from a congenital abnormality (palsy of some type). The mother is suffering from long standing back problems.

She lives in a flat positioned on the 2nd floor so she has to constantly carry her 3 year old child up and down the stairs, with her poor back, risking injury to herself and her child. Her child received weekly physiotherapy.

On one occasion, the occupational therapist came to their home to survey the apartment and identify where best to fit the exercise chair, which would allow the daughter to continue her exercise regimen outside of the centre. Upon surveying, the occupational therapist was shocked at the living conditions the family have been placed under and found it impossible for the youngest child to live here accordingly.

Subsequently, on January 2015 the occupational therapist wrote a letter to the housing officer stating the inhabitable living conditions and made recommendations for rehousing which is disability friendly. It appears prolonged stay in this apartment will hinder the quality of life the young child and her mother who has to bear her weight on an already weak back. The mother notes this process is taking very long.

The housing service is disjointed from the health service so miscommunication is frequent. The overcrowding coupled with disability unfriendly housing space is further complicating the child's disability and having negative knock on effects on the quality of life of the mother and the other children.

Case Study D

Issue: Mismanagement of care

Patient D is 54 year old diabetic woman. She suffers from ongoing pain (since a child) that has intensified with age – the constant muscle weakness sometimes prevents her from executing basic tasks such as getting up to go to the toilet when necessary so suffers from consequential incontinence. Some days the pain gets so bad she cannot go anywhere, this leads to missed GP appointments.

In one instance, patient D was given oral medication to control her glucose level. She asked the GP for a blood glucose meter to manage her glucose levels but the GP replied '*you do not need it*'. After some persuasion the GP agreed and informed her the nurse would provide it upon her next appointment.

At the next appointment, the patient came to the nurse and asked for the meter but the nurse denied her one. The nurse claimed the GP did not make a note of it in the patient's notes. After what the patient describes as 'begging' for access to a meter that will help her control her diabetes, the nurse finally gave her one.

Despite showing the patient how to use the machine physically, the nurse failed to explain what the figures on the meter meant and the thresholds for risk. Therefore, the patient could not utilise the apparatus effectively to manage her conditions. When the patient asked the nurse for clarification, the nurse told her to see her GP for explanation.

The patient informed the nurse she suffers from ongoing mobility issues so a further appointment with the GP may not be possible. The nurse dismissed the patients claims. Subsequently the patient became very ill, the pain in her lower limbs increased and she has been home bound for some time. For two months patient D has not been able to attend a GP appointment to ask her GP to explain how to use her glucose meter effectively.

Analysis and Conclusion

Twenty Nine surveys were completed through the following methods:
1) Self completion on a clipboard with researcher available for questions
2) One to one completion with a researcher
3) One to one with Somali organisation support worker

Although the respondent sample was small, feedback was gathered from service providers which see between 100-150 Somalis a month. Therefore, the service providers are well positioned to provide a comprehensive picture on the needs of the Somali community in Ealing.

Respondents were drawn from both those who used Somali support services in Ealing and from Somali residents using Ealing hospital that may or may not be currently using a Somali support service. The reason for this was even if some Somalis themselves did not access Somali support services they might be familiar with the issues of individuals that do.

There was a noticeable absence of feedback from young people. Many organisations identify these individuals as harder to engage and their missing voice should be viewed as an indication of unmet need.

Data illustrating health and wellbeing indicators of the Somali community in Ealing is scarce. Our work identified a gap in the Ealing CCG and the Council's knowledge of the health and wellbeing needs of Somali community in Ealing, we feel this could be met by stronger partnership working and more ground level research.

Casework feedback has highlighted instances of organisations running as 'self-help' groups. Many of these groups support Somalis through translation, writing letters of complaints, attending medical / council appointments with clients without receiving external funding.

But they are struggling to financially cope with the complex needs of many Somalis, often neglected or unaddressed by mainstream services, with many Somali organisations paying out of pocket for admin costs, travel etc.

We found high satisfaction with the Somali support services although it should be noted that we surveyed mostly individuals who were proactively engaging with support services.

Examples from casework where we did not survey individuals, project leads expressed higher levels of support needed to match demand.

From our survey and gathering feedback, we have found that people need support in accessing services and identifying how to use the NHS and social care services.

Accessing appropriate health and social care services poses difficulties for many Somalis and this is made harder by GP-Patient communication breakdown, living conditions and language barriers. There were reports of patients undergoing surgery without understanding the medical reasons and overdosing on medication because they did not understand the instructions for use.

Following the closure of multiple Somali support groups, Somali support service providers have noticed an increased demand on their already short staffed service. 71% of respondents noted they often have to wait longer periods to book an appointment and be seen. This increased demand puts pressure on existing services and their ability to meet the needs of all their clients.

In addition to barriers to access and the related language difficulties. Those using these support services also reported communication breakdown with their GPs. Many of the service users felt their clinical management of conditions by a GP was not adequate and issues were often not resolved until the individual saw a Somali organisation and had them write a letter of complaint.

Respondents who received mixed messaging from their GPs and hospital staff explained they had or were willing to seek medical care in another country. This further complicates the patient—GP relationship and deters patients from visiting their GPs when in need.

There was an identified gap between Somali community groups and the Council/ ECCG, which has left a level of distrust of external services by the community. This could be addressed by closer collaborations between the Council/ECCG and Somali groups. The Council and the Ealing CCG need to reach the Somali community in Ealing and the best way to do so is through the already established support organisations with whom they have a trusting relationship.

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Recommendations

This report found that specific and specialist support is needed to improve the quality of health and wellbeing of Somali residents living in Ealing. They need help to understand the services available to them and reduce access barriers to health and social care services to improve their quality of life.

Overarching Recommendations

1. Healthwatch Ealing recommends this report forms the work of the Health and Wellbeing Board with particular reference to addressing inequalities for the Somali community

2. Healthwatch Ealing calls on Ealing CCG, Ealing Council and NHS England London to engage with Somali residents and Somali support services to discuss the recommendations in this report to ensure they are at the heart of decision making processes around improving provision to the Somali community in Ealing.

Specific Recommendations

- Consultation sessions- The Council and Ealing CCG need to undertake engagement sessions with the Somali community where they have an open dialogue with the community and have representatives from key service areas such as housing, healthcare professional, benefits specialist etc. answering questions. It is important such engagement is widely advertised through the Somali community leads so the widest group of Somalis may be reached.

  In the summer 2016, Somali community groups will be coming together to host what they call an 'UN-Conference', a community dialogue conference. This conference will provide the community a chance to have an open dialogue with members invited from the CCG and the council. Somali residents will be able to direct questions around their health and social care needs to those who commission and implement the services.

  Therefore, we recommend health and social care commissioners to take this as an opportunity to support the Somali groups and ensure the representation of external bodies' is adequate.

- Health literacy - During clinical encounters, GPs need to make their communication ‘fit’ their patients' actual health literacy (Parker *et al.*, 1999). A few techniques they should adopt are: using simple language, slow down and ensuring an interpreter is available for those patients that need one.

- GP-Patient relationship - NHS England and Ealing CCG need to create engagement work with GPs and the community to build a level of trust and breakdown culture barriers to build strong patient-doctor relationships.

- It is important for Ealing Council (in particular Public Health) and Ealing CCG to work with Somali organisation leads, to reach the Somali community. Especially in the cases of health awareness of prevalent conditions such as diabetes.

- More data – There needs to be documented data on the Somali community in Ealing. Without data it is very hard for the stakeholders to understand the extent of the inequalities being faced by the Somali community, and given they make up a large number of the constituents of Ealing, this data will be crucial in contributing to the health and social care indicators in Ealing.

- The data did not capture the mental health dilemma in the Somali community. This came as a surprise given the prominence of mental health illness in this community. In order for the community to feel more comfortable discussing mental health illnesses there is a need for more community engagement work in this area of health and wellbeing

- Healthwatch Ealing will actively follow up the various stakeholders this report will be distributed to, to monitor the actions they undertake to address the recommendations in this report.

March 2016

Report Distribution

The report has been sent directly to the following :

- Stephen Day, Director of Adult Services, Percival House, 14-16 Uxbridge Rd, Ealing, London W5 2HL
- Dr Mohini Parmar, Chair Ealing Clinical Commissioning Group, 23 Oldfield Lane South, Greenford, UB6 9LF
- Dr Jackie Chin, Director of Public Health Ealing, Percival House, 14-16 Uxbridge Rd, Ealing, London W5 2HL
- Cllr Julian Bell, Chair Health and Wellbeing Board, L.B Ealing
- Cllr Peter Mason, Chair Adult Health and Social Care Scrutiny Panel, L.B.Ealing
- Care Quality Commission
- Healthwatch England
- NHS England
- Local GP surgeries
- London NorthWest Health Trust , Imperial Health Trust and Hillingdon Health Trust

References

- Parker, R. M., Davis, T. C. and Williams, M. V. (1999) Patients with limited health literacy. In Bateman, W. B., Kramer, E. J. and Glassman, K. S. (eds) Patient and Family Education in Managed Care and Beyond. Springer, New York, pp. 63–71.
- Spring School Census 2011. Spring School Census data.
- Office for National Statistics. Census 2001
- Children Services, Ealing Children and Young People Plan 2011-2014. 2012.
- Ealing Council(2014). Joint Strategic Needs Assessment 2014. Mira Mangara. Population Characteristic.

Appendix A

1. What is the biggest issue you face when accessing health and social care services? ***(Tick one)***

   Language barrier
   Waiting times
   Don't know which services are available to you
   Other (please specify)

2. For those of you who need an interpreter, how easy do you find the process of booking an interpreter for your GP/Hospital/social services appointments/visits ***(Tick one)***

   Very difficult
   Difficult
   Moderate
   Easy
   Very easy

3. Do you feel the housing conditions in which you live in affect you and your family's health? - *provide feedback on the type of housing service users live in* ***(e.g. social housing, private, rented, and what do people say are the most re-occurring housing conditions/ complaints (e.g. damp, insulation, number of rooms etc.).***

4. What do you think would happen if the Somali organisation you use no longer existed? - *identify if the service users are aware of alternative services?*

5. If you feel you have ever been poorly treated by a health or social care worker - have you personally accessed the NHS or social services complaints service? ***(Tick one)***

Yes
No

6. Do you know how to access the NHS or social services complaint service? ***(Tick one)***

Yes
No

7. How far do you travel to access your service? ***(Tick one)***

Walking distance
5-10 minutes
10-15 minutes
15-20 minutes
20-25 minutes
25-30 minutes
30+ minutes

8. Did the demand for your service change? ***(Tick one)***

Yes
No
I have not noticed

9. Do service users have to wait longer periods to have their issue dealt with now?

Appendix B

Name of Organisation:
Barwaqa Relief Organisation

Address: 63 mattock lane London W13 9 LA
Name and Contact details for lead officer: Hussein Dima
Email: hussein.barwaqa@lidocentre.org.uk **Telephone number:** 02082802284

What services do you provide?

- Teaching or supporting the extra learning to young people age 5-18 years old, the after school and weekend
- The organisation provide awareness and advice for the young people age between 16-20 years old once a month on the drugs, gangs, terrorising, give them specific advice on education .
- The charities provide the advice on the following: Housing benefit, child tax benefit, child tax credit, council tax benefit, Homeless, domestic violence, and employment .
- The organisation working with local tenant Association and support them and training every three months
- The organisation work with all local Somali resident and arrange them and discuss with if the any issue around them which liaising to local authority on behalf them.
- The organisation arrange event for the local resident especially on (two celebration of Muslim calendar)
- The Organisation arrange business groups and introduce them to local residents to see if any can support them through the brain storming session for an idea of business .

What services can you not provide based on the needs of the community?

We cannot provide a following: healthy advice on women, elder, women sport activities. Women health training and awareness etc.

How many staff do you have?

Four staff

How many Somalis are you reaching?

Every years we reach different numbers and this year we have reach 5342 people

In your view are there a large number people being turned away because of capacity issues?

Last four weeks we had to close down 70% of our activities and many of our users had to be turned away which is unfortunate, but we did not have an option since our funding has been greatly reduced.

What has been the impact of the reduction of the active Somali organisations in Ealing on the demand for your service?

Demand increased in all areas which affect the community. Such as on all benefit advice, homelessness, health, language barriers etc.

Where do you get funding? How do you get funding?

Normally our funding is part from local authority Ealing, other from different trust but this year we haven't received any support from Ealing so we have hardly survived.

Name of Organisation:
Horn of Africa Disability and Elderly Association (HADEA)
Address: Lido Centre, 63 Mattock Lane, London, W13 9LA
Name and Contact details for lead officer: Yusuf Guled
Email: hadeaoptions@gmail.com **Telephone number:** 07980614391

What services do you provide?

- Information Advice and Guidance: Welfare rights advocacy work, Disability rights advocacy work, Guidance, advice and Information on; Immigration issues, Social housing, Direct payments and so on. We delivered on the Ealing GRAPE project in conjunction with Havelock Family centre to support vulnerable adults
- Interpreting/Translating: Provision of interpreting and translation services to the clients and outside organisations
- Referrals: HADEA works with outside organisations depending on the nature of the needs of the clients. HADEA refers clients to organisations such as the GPs, Social Services, Ealing Advice Services to name but a few.
- Health Promotion and Provision: HADEA provides health information, advice, and guidance and organises events based on health needs of the targeted clients group. This year we delivered promotions and support on; Diabetes, Heart Conditions; Blood Pressure and healthy living and lifestyles. We worked in partnership with Southall Community Alliance to deliver swimming programme for 45 young people at Dormers Wells Sports Centre
- Outreach Advocacy: The service targets the most vulnerable adults and parents of children with especial needs by providing them with relevant information, advice and guidance. We do regular home visits, phone calls or arranging transport for the users to come to our centres in order to seek the support they need and when needed it. This is the diagnostic stage and after it has been agreed what is best for the use, the necessary arrangements tare made where it might involved referrals to appropriate services
- Disability Intervention: We delivered a number of volunteer led projects for disabled adults, children and their families/carers. We delivered on the Southall Big Plan a family support project for families with disabled children in connection with Ealing's P.E.S.T service.
- Financial Literacy: HADEA supported users with debt/financial issues through its partnership D0$h project led by Catalyst Housing and Havelock Family Centre on their financial literacy project.
- Old is Gold project: Awards for all funded project that looked at supporting marginalised elders within the borough on a range of issues; such as housing, health and mobility.

What services can you not provide based on the needs of the community?

HADEA is unable to deliver community education and employability projects - which are great demanded by our service users. HADEA cannot deliver end to end projects i.e. complete health intervention projects - due to lack of resources.

How many staff do you have?

One part time staff (10hrs/week). HADEA depends on the work of its volunteers.

How many Somalis are you reaching?

HADEA has foot-fall of Somali users in the region of 1000 users year. HADEA also see clients who come from other boroughs.

In your view are there a large number people being turned away because of capacity issues?

HADEA has become smart in how it delivers its projects - some of which are completely volunteer led. All our projects are delivered in parts and the basic support we provide is: provide information, sign post and refer client to other services. We try our best not to turn away clients - and so we register them and provide some sort of assistance no matter how miniscule.

What has been the impact of the reduction of the active Somali organisations in Ealing on the demand for your service?

Catastrophic and disastrous. The community remains the only large community in the borough that has nearer to nil support from civil societies and statutory organisations.

Where do you get funding? How do you get funding?

HADEA receives funding mainly from grants funding and some of the funds have come from local government. HADEA has also secured some small funds from the Big lottery. HADEA depends on the good will of a Somali pro-bono consultancy firm to do its funding bids.

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