Kensington, Chelsea & Westminster BME HEALTH FORUM:

TASK GROUP ON EXPERIENCES OF MUSLIM WOMEN USING HEALTH SERVICES

FINAL REPORT:
SUMMARY AND RECOMMENDATIONS FROM COMMUNITY CONSULTATIONS
August 2002

The issue of Access to Health Services by Muslim Women was identified following one of the recommendations of a year-long consultation with BME communities in Kensington & Chelsea and Westminster that led to the setting up of the BME Health Forum, as well as following the recommendations from the Conference on "*Improving Health and Social Care for the Arabic-Speaking Community in Kensington & Chelsea*".

A Task Group was set up by the BME Health Forum with the aim of undertaking a mini action-research project. Local community groups, hospitals and G.P. practices working with Muslim women from different nationalities were invited to join the Task Group. As part of this Task Group, the BME Health Forum commissioned community groups to undertake a series of consultations with community members and users of their services to find out problems and issues related to access to health services.

The focus was on issues of access to primary care, hospital and community health services, women's services, services for children and young people, as well as other specialist services such as dentists, physiotherapists, counselling, advocacy, etc. Statutory agencies were also invited to participate in these sessions, to enable them to link this with other consultation work they may already have been undertaking. St Mary's Hospital undertook a series of in-patient consultations, both at the hospital and in G.P. surgeries they work with.

This report and action plan is the final report from the Task Group. The BME Health Forum will continue to be involved in follow-up action on the recommendations from the Task Group – this will be co-ordinated by the Women's Officer, based in Westminster PCT.

The BME Health Forum would like to thank all those who participated in the Task Group, and especially representatives from community groups who held consultation events.

METHODOLOGY

This Task Group was made up of representatives from community & voluntary groups and statutory agencies. An initial meeting took place where participants suggested that a co-ordinated approach needed to be developed by all those undertaking and facilitating the consultation sessions. Participants also said that they would like to be provided with training on how to run community consultations, and that they would need to be funded to run these consultation sessions.

The BME Health Forum funded community organisations to run consultations. These were done with at least 6-27 participants in each, and the groups provided a written report whose findings are included in this report.

The BME Health Forum also organised 2 training sessions with an experienced trainer, on how to run community consultations; and one workshop on developing the consultation questionnaire / discussion points.

Regular meetings were held throughout the process and the Forum, in partnership with the KCW Community Health Development Team, provided community groups with extra capacity support including the provision of a facilitator and a note- taker. Statutory agencies such as Hospital Trusts and G.P surgeries were also invited to run consultations with their users and as a result, St Mary's Hospital Trust ran a series of consultations with in-patients, as well as out-patients.

Although the Task Group took one year to achieve its objective, the process proved to be a successful mechanism for providing a co-ordinated approach to getting feedback from various communities and community organisations. The Task Group was a successful structure whereby community organisations, statutory agencies – including Hospital Trusts, Primary Care Trusts, Social Services, local and national voluntary organisations were involved, on an equal basis and from the outset. This process involved carrying out the aims and objectives of the Task Group in developing the questionnaires and undertaking the community consultations. Findings and recommendations from other relevant reports have also been included in this report.

This is the final report from the Task Group and it includes findings from the consultations and recommendations for future service- provision. Although this is the end of the Task Group, the group will continue to meet and Kensington & Chelsea and Westminster PCTs will take the lead in this – the Women's Officer will co-ordinate follow-up work. The BME Health Forum will continue to be involved in this group, and in lobbying for the recommendations from the community consultations to be taken up by service- providers – both voluntary and statutory – and commissioners.

It is envisaged that the BME Health Forum – with the members of the Task Group - will continue to monitor how the recommendations and findings from the report are taken forward.

CONSULTATIONS UNDERTAKEN:

- Consultation event with *Al-Najat* Women's Group in partnership with KCW CHDT. Number of attendees: 16 women.
- Consultation event with *Al-Hasaniya* Moroccan Women's Centre. Number of attendees: 8 women.
- Consultation event with Sudanese Mothers For Peace in partnership with KCW CHDT. Number of attendees: 10 women.
- Consultation event with the Egyptian Community Centre. Number of attendees: 15 women.
- Consultation event with Somali Welfare Association. Number of attendees: 14 women.
- Consultation event with the Egyptian Women's Group in partnership with Parkside NHS Trust (specific focus on HIV, Sexual Health and Arabic-speaking Communities).
- Consultation event with Iranian Men and Women in partnership with KCW CHDT. Number of attendees: 25 men and women.

- St Mary's Hospital Trust consultation event at the Muslim Cultural Heritage Centre. Number of attendees: 27 women.
- St Mary's Hospital Trust one-to-one interviews with out-patients. Number of interviewees: 6 women
- St Mary's Hospital Trust consultation in local G.P. Surgery. Number of attendees: 6 women.

OTHER REPORTS:

- Arabic-Speaking Community Groups in Kensington & Chelsea, (November 2000). Report from Half-Day Conference on "*Improving Health and Social Care for the Arabic-Speaking Community in Kensington & Chelsea*"
- Minutes of "Experiences of Using Health Services by Muslim Women" Task group.
- Queens Park Bangladeshi Association and Imperial College of Science Technology and Medicine, (January 2002). Bangladeshi Community Involvement and Action Project: *Report of a cross-sectoral rapid assessment and response project to characterise the condition, well-being and community development needs of the Bangladeshi community living in the North Paddington area and to develop interventions that promote well being and support development.*

MEMBERS OF TASK GROUP & PROJECT STEERING GROUP

1.	Annie-Mae Shaw	New Roots
2.	Khadija Hussein	Mothers for Peace
3.	Yomi Oni-Williams	KCW CHC
4.	Samira Ben Omar	BME Health Forum
5.	Wafaa Benjelloun	GRIP Language Services
6.	Anna Barnes	Westminster PCG
7.	Assiya Yousef	Yemeni Community Association
8.	Madhu Agarwal	Cancerlink
9.	Marc Thompson	Golborne United SRB
10.	Fatima Mehabli	Yemeni Community Association
11.	Umbreen Daechsel	Westminster City Council
12.	Noura Mohamed	Somali Welfare Association
13.	Norma Golding	Health Support Team
14.	Esther Moloney	St Mary's Hospital
15.	Salwa Al-Saeedi	Yemeni Community Association
16.	Aisling Byrne	BME Health Forum
17.	Renee De La Haye	K & C Primary Care Group
18.	Amira Gorani	K & C Health Authority
19.	Karima Koia	*Al-Hasanyia* Moroccan Women's Project
20.	Shivani Kundapur	Sure Start
21.	Ghada Mansour	Al Najatt Group
22.	Ahmed Ali	Somali Parents & Children's Association
23.	Kate French	Trainer
24.	Mawahib M. Azteg	Sudanese Mothers for Peace
25.	Anne Cleary	St. Mary's Hospital
26.	Katija Huijbers	MRCF
27.	Fidaa Mahmoud	MRCF
28.	Roohy Shahin	Persian Care Centre

29. Jo Shim	Community Health Council
30. Laila Hafidi	St Mary's Hospital / GRIP
31. Papia Hussain	Local Resident / Community Volunteer
32. Bridget Davies	Minute Taker

FINDINGS

Although this Task Group focused specifically on access to health services, the findings and the recommendations have implications equally for health and social care – in particular social services – service providers and commissioners, from both the voluntary and statutory sectors.

1. Awareness of Current Mainstream Health Services

Overall, almost all participants were registered with a G.P practice and had used hospital services and were aware of the availability of interpreting services. There was a general **misconception about the role of health service professionals** and lack of awareness of the services provided in Primary Care settings - this includes the roles of GPs, nurses, counsellors, health visitors, etc. Furthermore, the issue of access to female GPs and other clinical staff was highlighted throughout the consultation process.

The level of awareness of the services provided varies according to two categories: those already established in this country, all of whom are registered with a doctor, and new arrivals – in particular asylum -seekers placed in temporary accommodation or those who had returned to London following dispersal. People recently established and **new arrivals seemed less informed about their entitlements** to free health care and other benefits.

In terms of awareness of primary, secondary and specialist health services the issues highlighted involved:

1.1 Primary Care Services:

- Although most women were registered with a G.P. surgery, they very rarely visited their doctor. Many said that this was because there was a **long waiting list for appointments** - usually 2 – 3 weeks.

- Most women were not aware of other services provided by the G.P. practice such as counselling, access to a nurse for general health advice, health visitors. A majority of women with children stated that they had never been explained the role of health visitors and thought that they only visit for vaccination purposes.

- **Awareness of complaints procedures:** Although a large number of women were dissatisfied with their G.P., none of them knew that there was a complaints procedure in place. They also stated that **they would not complain as they had found it extremely difficult to find a G.P.** who was willing to take them on in the first instance, and did not want to go through the same process again.

- Many women also stated that primarily **the role of their G.P. was to refer them to a specialist rather than provide diagnosis**. This often leads to tensions between the G.P and the Patient.

- **None of the participants knew about NHS** Direct and that they provided language facilities.

- The participants were also **not aware of Minor Injuries Units, and Walk-In-Clinics.**

1.2 Hospital Services:

- One issue that was overwhelmingly highlighted in all the consultation exercises was **the issue of mixed wards**. All women felt that mixed wards were **not appropriate as they did not provide privacy**; and the majority of women remained enclosed in their cubicles for the whole period of their hospitalisation. Although some women asked for a single sex ward, the majority were not aware who they should ask.

- Awareness of hospital facilities: A large number of participants were not aware of the facilities available within St Mary's, including access to prayer facilities: many ended up praying in their own cubicles. Although all the participants had stated that they were provided with *halal*/vegetarian meals, they were not informed about this beforehand and many ended up asking their families to bring them food from home.

- Flexible visiting times: Overall, **participants were very happy about being allowed visitors at various times** as their partners often worked in the evenings and could only visit during the mornings.

- **Awareness of Hospitalisation and Discharge procedures:** Participants had a mixed reaction in terms of the information given to them by the hospital staff. However, **overall the feedback was very positive**. Some participants said that they were given information in their mother-tongue about the procedures and support services once they were discharged. One woman stated that she was shown a video about the support services available and she found it very reassuring. She was also visited by a nurse at home, who was able to go through the medication with her.

2. Women's Services and Sexual Health Services

Participants were also asked about their awareness of ante/post- natal services, family planning, cervical screening, breast screening and sexual health services such as G.U.M clinics.

- **Ante/post-natal services and family planning:** most women were informed of these services by their G.Ps / nurse once they became pregnant; although a large number of **women felt that they did not understand why they needed to visit the ante-natal clinics** and some did not attend at all. In terms of **ante-natal exercises**, the majority were not informed of any activities and stated that even if they were, they would

not attend as these classes were not exclusively for women and they felt were therefore **not culturally appropriate for them**.

- Cervical and Breast Screening services: Participants were more aware of Cervical than Breast Screening services. When asked how often they had had Cervical Smears done, women above 50 years of age said that once in your lifetime should be enough. Those with more awareness about Smear Tests were overwhelmingly mothers with young children born in the UK. In terms of **Breast Screening services**, **most older women didn't know about them:** they said that they weren't relevant to them. Furthermore, some of those who had attended an appointment for breast screening said that the clinic was very far away and they had a very stressful experience and found it difficult to communicate with staff as the service did not provide interpreters. They also felt very exposed and humiliated as the changing area was very far from the consultation room. Most of those who attended the clinic said that they would not go back. When asked whether they would attend a session if it was within a mobile clinic held within a community setting, they said this would be better.

- **Sexual Health Services: Most** of those consulted **had no knowledge of any sexual health services** available and thought that that this was not relevant to them. They did, however, express concerns about thrush and urine infections and stated that they only consulted their G.Ps once the problem became acute.

3. Provision of Interpreting Services

- **Most women were aware of interpreting services available**, some said that they still used their relatives, including their young children, to interpret for them. The underlying reason for this is the issue of confidentiality: they felt that their community is very close knit and that they did not want other people to find out about their health or family problems.

- Participants stated that **health professionals** – including front-line staff – were **not pro-active in providing interpreting services**. When a client asked for an interpreter, they felt health professionals were very reluctant to provide one. In one case, when an elderly client requested an interpreter from the receptionist at her G.P. practice she was told that they did not provide interpreting services and that she should register with an Arabic-speaking G.P.

- **Some women highlighted that their appointments were usually for 20 minutes, instead of the allocated 10 minutes,** when they were provided with an interpreter. All participants felt that **this was good practice** as it would allow them to discuss their health problems with their G.Ps properly

- Interpreting medication: Currently **no one has the task of interpreting medication**. Women felt that this should be part of the interpreting.

- It was felt that there is a lack of provision of **interpreters who speak the same dialect**, are of the same gender and are familiar with the cultural and religious background of the patient.

4. Provision of adequate / culturally sensitive Health Services

- In relation to St Mary's Hospital, many women said that they know **prayer facilities** are available, however, they emphasized that the area was too small and not segregated. It would be better if they divided the area into two sections, one for men and another for women.

- **Provision of Halal Food**: Most women said that they were given the option of having either Halal or vegetarian food, and they felt this made a big difference as before family members would have had to bring in food for them

- **Signage in mother-tongue languages:** All those consulted felt that finding their way through St Mary's Hospital was very difficult, and some patients had lost their appointments because they couldn't find their way. All those consulted stated that it would help greatly if the signs were in different languages. Furthermore, they also emphasised that GPs should put up notices in different languages, particularly in relation to the provision of interpreting services, so that patients would know that they could ask for an interpreter should they require one.

- **Provision of translated appointment letters / cards:** Many participants said that they missed their hospital appointments because they couldn't read the letter. They suggested that it would be better if the letters were sent in mother-tongue; or if the patient was illiterate, in their native language. It would help a lot if patients were contacted by telephone by the interpreter near the appointment date.

- Participants gave good feedback on **hospitalisation and discharge procedures**. Many said that these were provided in different languages and using different methods such as videos, etc. One patient gave a very good example where she said that she was given information in Arabic about the procedures and support services on discharge. Another woman stated that she was shown a video about the support services available once she was discharged, and she found it very reassuring. She was also visited by a nurse at home, who was also able to go through the medication with her.

- Patients felt that more and improved cultural awareness training should be provided for all staff– including front-line staff like receptionists.

5. Health and Social Care Professionals

- Patients' overall perceptions of **nurses and health visitors** were that they are more *"gentle and caring and easier to talk to than doctors"*

- Users had the perception that **frontline staff** – both in primary care settings and in hospitals – are less sympathetic and often prejudiced and *"favour other patients over muslim ones"*. This, women felt, has become

more apparent following the events of Sept. 11th where those wearing scarves felt intimidated by staff; and some said that they *"stopped visiting their G.Ps altogether to avoid all the problems"*.

Furthermore, many women said that they found it very difficult to register with a local practice and that practice staff always gave the excuse that they are either beyond the practice boundary or that they're full. One example was where a woman said that she *"tried to join the same practice as her neighbour and was told that she fell outside the boundaries of the practice".*

- In relation to **G.Ps and Hospital consultants,** many women complained that they wre perceived as being difficult and a problem and that their concerns were not taken seriously. One woman stated that she *"had an appointment with my G.P. about my back problem and he didn't bother to examine me. Instead he only wrote a repeat prescription and handed it to me at reception, whereas the next patient was ushered into his consulting room"*.

- Many women on Income Support say that GPs refuse to **prescribe medication** such as *Calpol* and *Paracetamol* for their children and emphasise that they should buy it over the counter.

- Women were also concerned about the fact that very often during their hospital visits, or as in-patients, consultants brought in **trainees** without the prior consent of the patient.

- More and improved **cultural awareness training** should be provided for all staff– including front-line staff like receptionists. This should include visits to local community groups – which could also be included in induction programmes for new staff.

6. Issues for Refugees and Asylum Seekers

Although some asylum seekers were registered with a G.P. there is still a misconception about their entitlements to free health care. Many have stated that practices have turned them down on the basis that they have said that they were asylum -seekers. Those registered with a G.P and in receipt of vouchers only have said that very often doctors became very impatient when they were asked to prescribe medicine either for themselves or for their children.

Those recently established and new arrivals seemed less informed about their entitlements to free health care and other benefits. In terms of awareness of primary, secondary and specialist health services the issues highlighted involved the following points:

6.1 Women have also stated that other factors are not taken into account including:

- **Immigration Status**: Participants have highlighted that their status very much adds to their stress and anxieties, resulting in health factors including stress -related illnesses such as depression, as well as other physical illnesses.
- **Housing**: A large number of participants raised concerns about the very poor quality accommodation that they were placed in, including

overcrowded housing, and the effects of this on their health and well-being.

- **Access to Schooling**: There are also health implications for children who are deprived of going to school as they will not register them if they are not permanent residents; and they spend months at home.
- **Unemployment:** Asylum -seekers are not entitled to work: this often impacts on the health not only of the individual, but also of the whole family.

7. Good Practice in the process of running community consultation events

- An important outcome from this Task Group has been the **process** adopted for the community consultations.

- A **capacity development** process was adopted; this involved organising a **training session** on how to run community consultations, with resources and materials provided; **support** on preparation and planning for running community consultations; development of a ***pro forma* questionnaire**; and involvement of the groups and organisations engaged in the **process and policy-development aspect** of the Task Group.

- Members of the Task Group felt that the support, training and resources that were provided helped them to run **well-planned and more strategic consultation events**, and enabled them to see how their feedback would contribute to the policy-making and commissioning process for services.

- Given this, it was suggested that as good practice, **NHS Trusts should offer capacity development and resource support to community groups** when they are involved in consultation events. This should include payment to the group (for venue, refreshments, child care, etc.), training on running sessions, production of a pro forma on the aims and objectives of the session, involvement in the process of how feedback will be taken up by commissioners and service- providers, and involvement in meetings related to the project throughout its duration.

- Given the **requirements of the Race Relations Amendment Act** and the obligation to involve BME communities in consultation and all aspects of the organisations' policies and procedures relating to race equality, together with developments around the new public and user- involvement structures (PALS, Patient Forums, local Commissions, etc.), these good practice recommendations will assist NHS bodies with these requirements.

- It was suggested that the requirement to involve communities in consultation initiatives – as per the Race Relations Amendment Act – should be **built in to service level agreements and contracts** with service- providers (statutory and voluntary) to ensure that this process is mainstreamed and that consultation and feedback are received in a sustainable and effective manner.

RECOMMENDATIONS

8. Service-Providers and Commissioners

One underlying outcome of the consultations undertaken has been the need to develop a **multi-agency, genuine partnership approach** to service- planning, development and delivery. This should include Health and Social Care service-providers and commissioners – PCTs, Hospital Trusts, Mental Health Trusts, Social Services – grassroots community organisations as well as umbrella organisations and local training providers.

Grassroots community and voluntary sector organisations need to be provided with **capacity support** – including funding for core costs, organisational development support, etc. – in order to engage effectively, in an on-going manner and on an equal basis with statutory sector providers and commissioners.

A formal, **effective and co-ordinated structure for taking forward grassroots community issues at a strategic level** needs to be developed. The previous KCW *Facing Up to Difference Strategy Group* (co-ordinated b the KCW Health Authority) where community, voluntary and statutory sector representatives met to address the health and social care strategic policy issues affecting the local BME communities provided a format for this, and it is recommended that a similar co-ordinated structure be developed.

8.1 Primary Care Services:

- **Long waiting times for GP appointments:** some GPs practices are over-subscribed and as a result have an average waiting time for appointments of about 2 – 3 weeks. The reason for this is that either the practice is staffed by bi-lingual nurses, GPs, frontline staff etc., or that it has developed an automatic system for providing interpreters for patients and provides women with the option of registering with a female doctor.

- **Awareness and cultural appropriateness of services provided:** Most women were not aware of other services provided by the GP practice such as counselling, access to a nurse for general health advice, health visitors. The majority of women with children stated that they had never been explained the role of health visitors and thought that they only visit for vaccination purposes.

- **Awareness of complaints procedures:** Although a large number of women were unsatisfied with their GP, none of them knew that there was a complaints procedure in place. They also stated that they would not complain, as they had found it extremely difficult to find a G.P. who was willing to take them on in the first instance and did not want to go through the same process again.

- **Misconceptions about the role of the GP:** Many women stated that primarily the role of their G.P. was to refer them to a specialist, rather than provide diagnosis. This often leads to tensions between the G.P and the patient.

- **Awareness and Use of NHS Direct:** Very few of the participants knew about NHS Direct, and none were aware that they provide language facilities.

- **Awareness Minor Injuries and Walk-in-clinics:** The participants were also not aware of Minor Injuries Units, and Walk-In-Clinics.

8.2 Hospital Services:

- **Provision of Single Sex Wards:** One issue that was overwhelmingly highlighted in all the consultation exercises was the issue of mixed wards. All women felt that mixed wards were not appropriate as they do not provide privacy, and the majority of women remained enclosed in their cubicles for the whole period of their hospitalisation. Although some women asked for a single sex ward, the majority were not aware about whom they should ask.

- **Awareness of Hospital facilities:** A large number of participants were not aware of the facilities available within St Mary's, including access to prayer facilities: many ended up praying in their own cubicles. Although all the participants stated that they were provided with halal/vegetarian meals, they were not informed about this beforehand, and many ended up asking their families to bring them food from home.

- **Flexible visiting times:** Overall, participants were very happy about being allowed visitors at various times, as their partners worked in the evenings and could only visit during the mornings.

- **Awareness of Hospitalisation and Discharge procedures:** Participants had a mixed reaction in terms of the information given to them by the hospital staff. However, overall feedback was positive. Some participants said that they were given information in their mother-tongue about the procedures and support services once they were discharged. One woman stated that she was shown a video about the support services available on discharge and she found it very reassuring. She was also visited by a nurse at home, who was able to go through the medication with her.

8.3 Women Services and Sexual Health Services

- **Ante/post-natal services and family planning:** most women were informed of these services by their GPs/nurse once they became pregnant, although a large number of women felt that they did not understand why they needed to visit the ante-natal clinics and some did not attend at all. In terms of ante-natal exercises, the majority were not informed of any activities and stated that even if they were, they would not attend as these classes were not exclusively for women and were therefore not culturally appropriate.

- **Cervical and Breast -screening services:** Participants were more aware of cervical rather than breast- screening services, although when asked how often they have had cervical smears done, women above 50 years of

age said that once in your lifetime should be enough. Those with more awareness about smear tests were overwhelmingly mothers with young children born in the UK. In terms of breast -screening services, most older women didn't know about breast -screening, and said that it wasn't relevant to them.

Furthermore, some of those who had attended an appointment for breast-screening said that the clinic was very far away. They had a very stressful experience and found it very difficult to communicate with staff as the service did not provide interpreters. They also felt very exposed and humiliated as the changing area was very far from the consulting room. Most of those who attended the clinic said that they would not go back. When asked whether they would attend a session if it was within a mobile clinic and with a community worker, they said this would be good.

- **Sexual Health Services:** Most of those consulted had no knowledge of any sexual health services available and thought that this was not relevant to them. They did, however, express concerns about thrush and urinary infections and stated that they only consulted their GPs once the problem became acute.

  For further information on sexual health issues, please refer to the BME Health Forum Task Group recommendations on "*HIV, Sexual Health and BME Communities".*

8.4 Provision of Interpreting Services

- **Issue of Confidentiality:** Although most women were aware of interpreting services, some said that they still used their relatives, including young children, to interpret for them. The underlying reason for this is the issue of confidentiality: they felt that their community was very close knit and that they did not want other people to find out about their health or family problems.

- **Pro-active approach to the provision of interpreting:** Participants also stated that health professionals – including front-line staff – are not pro-active in providing interpreting services; and when a client asks for an interpreter, health professionals are very reluctant to provide this service. In one case, when an elderly client requested an interpreter from the receptionist at her GP practice - she was told that they did not provide interpreting services and that she should register with an Arabic-speaking GP.

- **Double appointments for patients requiring interpreters:** Some women have highlighted that their appointments were usually for 20 minutes, instead of the allocated 10 minutes, when they were provided with an interpreter. All participants felt that this was a very good practice as it would allow them to discuss their health problems properly with their GPs

- **Interpreting medication:** Currently no one has the task of interpreting medication. Women felt that this should be part of the interpreting process.

- **Provision of interpreters who speak the same dialect:** Lack of provision of interpreters who speak the same dialect, are of the same gender and are familiar with the cultural and religious background of the patient.

  Please also refer to the BME Health Forum Task Group recommendations on "*Feedback from Informal Consultation on GRIP Interpreting Services",* as well as the recommendations from "Evaluation of Interpreting Services in KCW and Brent & Harrow Health Authorities" by SILKAP CONSULTANTS.

8.5 Provision of Adequate / Culturally Sensitive Health Services

- In relation to St Mary's Hospital, many women stated that **Prayer facilities** are available. However, they emphasized that the area was too small and not segregated. Prayer facilities **should be divided into two sections**, one for men and another for women.

- **Provision of Halal Food:** Most women said that they were given the option of having either Halal or vegetarian food and they felt this made a big difference, as before family members would have had to bring in food for them.

- **Signage in mother-tongue languages:** All those consulted felt that finding their way through St Mary's Hospital was very difficult, and some patients had missed their appointments because they couldn't find their way. All those consulted stated that it would help greatly if the signs were in different languages. Furthermore, they also emphasised that GPs should put up notices in different languages, particularly in relation to the provision of interpreting services, so that patients would know that they could ask for an interpreter should they require one.

- **Provision of translated appointment letters / cards:** Many participants said that they missed their hospital appointments because they couldn't read the letter. They suggested that it would be better if the letters were sent in mother-tongues; or if the patient was illiterate in their native language it would help if they were contacted by telephone by the interpreter nearer to the appointment date.

- **Good Practice on Hospitalisation and Discharge Procedures:** Participants gave good feedback on hospitalisation and discharge procedures. Many said that these were provided in different languages and using different methods such as videos etc. One patient gave a very good example where she said that she was given information in Arabic about the procedures and support services once patients were discharged. Another woman stated that she was shown a video about the support services available once she was discharged and she found it very reassuring. She was also visited by a nurse at home, who was also able to go through the medication with her.

- **More and improved cultural awareness training** should be provided for all staff – including front-line staff like receptionists.

8.6 Health and Social Care Professionals

- Patients' overall perceptions of **nurses and health visitors** are that they are more *"gentle and caring and easier to talk to than doctors"*

- Users had the perception that **frontline staff** – both in primary care settings and in Hospitals – were **less sympathetic** and often **prejudiced** and *"favour other patients over Muslim ones"*. This, women felt, has become more apparent following the events of Sept. 11th, where those wearing scarves felt intimidated by staff and some said that they *"stopped visiting their GPs altogether to avoid all the problems"*. Furthermore, many women said that they found it very **difficult to register with a local practice** and that practice staff always gave the excuse that they were either beyond the practice boundary or that they were full. One example was where a woman said that she *"tried to join the same practice as her neighbour and was told that she fell outside the boundaries of the practice".*

- In relation to **GPs and Hospital consultants** many women complained that they are perceived as being difficult and a problem and that their concerns are not taken seriously. On woman stated that she *"had an appointment with my G.P. about my back problem and he didn't bother to examine me Instead he only wrote a repeat prescription and handed it to me at reception, whereas the next patient was ushered to his consulting room"*.

- Many women on Income Support say that **G.Ps refuse to prescribe medication** such as Calpol and Paracetamol for their children and emphasise that they should just buy it over the counter.

- Women were also concerned about the fact that very often during their hospital visits or as in-patients, **consultants bring in trainees** without the prior consent of the patient.

- More **and improved cultural awareness training** should be provided for all staff providing staff – including front-line staff like receptionists with specific focus on local issues. The training should be taken in partnership with local grassroots and umbrella organisations.

8.7 Preventative Work, including Health Promotion

- To **develop** information, awareness and consultation **sessions jointly with grassroots community organisations** and within community settings.

- Provide awareness sessions on new public and user involvement initiatives particularly in relation to PALS and Patient Forums. Develop joint projects whereby **PALS officers are placed** within statutory as well as **community sectors** to ensure community-based service provision and on-going user feedback.

- Look at current **good practice examples** of provision of information on hospitalisation and discharge procedures and **extend them to other**

services, including primary care services. A number of women cited examples of St Mary's Hospital providing information in mother-tongue languages both on discharge procedures and support services once they were discharged.

- **Working with Community organisations** to **raise awareness** on particular services including Breast -Screening, Cervical Smear Tests, Access and Entitlements to Dentists, Opticians etc, and developing formal **structures for on-going user feedback** to ensure that concerns are taken into account when developing or restructuring these services.

- **Awareness and information** sessions on **specialist services,** including Dentists, Opticians, Community Dieticians, Walk-In Clinics, and **NHS Direct.**

8.8 Partnership projects between community and statutory sectors

One underlying outcome of the consultations undertaken has been the need to develop a **multi-agency, genuine partnership approach to service planning, development and delivery**. These should include Health and Social Care service providers and commissioners – PCTs, Hospital Trusts, Mental Health Trusts, Social Services – grassroots community organisations as well as umbrella organisations and local training providers

Grassroots **community and voluntary sector organisations** need to be **provided with capacity support** – including funding for core costs, organisational development support etc. – in order to engage effectively, in an on-going manner and on an equal basis with statutory sector providers and commissioners.

Given the above and the outcome of the consultations in terms of the need to recruit **bilingual health and social care professionals** as well as frontline staff, there needs to be developed a short-term as well as long-term measures to address difficulties in accessing current mainstream services and the gap in service-provision. The recommendations, therefore, are to:

- **Link** in current local initiatives on **training for health advocates** (e.g. MRCF Training on Health Advocacy) to current recruitment drives within the PCTs and other Trusts to employ PALS Officers
- **Extend** the current joint **Refugee Doctors Scheme to** include **nurses and health care assistants**
- **Provide long -term** training and **employment opportunities** for members of the **local community**
- **Undertake a skills Audit** locally and **match it** with current **local health and social care vacancies**.
- **Recruit bi-lingual community link-workers** based part-time in a community setting and part-time in a statutory setting.
- **Develop "satellite" nurse led clinics within community settings,** providing basic health checks, information and advice and **link it to PALS service.**
- **Develop A Training / Capacity Support** Programme for the Task Group members in consultation with them.

FOLLOW-UP WORK

If you would like further information on how the findings and recommendations from this Task Group will be taken forward, please contact:

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