



Have Your Say!

Identifying the Health, Housing and
Support Needs of African & Caribbean
Older People in London Borough of
Ealing

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October 2010***

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Have Your Say!

Identifying the Health, Housing and Support Needs of African and Caribbean Older People in Ealing – A Research Study

1. Introduction to the Research Study

The purpose of the Research Study was to gather information concerning the health, social care and housing needs and experiences of older people from African, Caribbean and Somali communities living in the London Borough of Ealing. The information gathered would be used to inform the ongoing development of services to meet those needs.

The Research Study was undertaken as a partnership between the United Anglo-Caribbean Society (UACS) and the Department for Health and Social Care, Royal Holloway, University of London. Funding for the project was kindly provided by the Ealing NHS Primary Care Trust.

It was important to ensure that whatever research methods were used, were acceptable and appropriate to the community we needed to talk to. Therefore a group of volunteer community researchers were recruited by UACS, and trained by Royal Holloway to administer a semi-structured interview schedule to the target community; there were 50 interviews completed. To consolidate and explore the issues further, UACS ran four focus groups/discussion groups across the borough, involving 30 people. The fact that the volunteer researchers lived and/or worked locally and were from the African Caribbean community made it possible to reach residents considered 'hard to reach' and ensure that the responses they made were as open and candid as possible.

2. Background information

For more detailed information on demographics, national and local strategies and guidance, as well as best practice in the delivery of health, housing and social care services please see Appendix 1.

The overall population in the London Borough of Ealing is approximately 300,000; people over the age of 65 make up 11.6% (34,000) of this figure. More than 40% of the general population in Ealing are from Black and minority ethnic communities (BME); with 25% identifying themselves as Asian or Asian British, 8.8% of the local population identify themselves as 'Black British' and, 3.6% of the population consider themselves to be 'Mixed Race'. We do not have data concerning the numbers or proportions of African, Caribbean or Somali people living locally and over the age of 60-65 years. We do know that the Somali community in Ealing has grown within the last 10 years due to the arrival of refugees; Somalis make up 29% of the local refugee population (LB Ealing, 2005b) and somewhere between 3-10% of the total population (ibid) in the borough. The London Borough of Ealing is the fourth most diverse local authority in the country.

It has been estimated that by 2011 28% of Ealing's older people will be made up of BME (Black and Minority Ethnic) communities, within this 7.5% of Ealing's older population will be from African, Caribbean or other Black communities (Ealing PCT, 2006). It is worth noting that the age profile of the Caribbean population in Ealing is older than that of the African (LB Ealing, 2005b), due to immigration trends during the last 50 years.

Similar to other London boroughs Ealing includes pockets of affluence and pockets of high deprivation (for example, Southall and Acton); within the deprived neighbourhoods live a high proportion of the BME population. The African-Caribbean community are concentrated in Acton and the northern wards of the borough (Ealing, 2005b).

A continuous and overarching theme of local and national frameworks and guidance for the past decade has been to promote the ability of older people to live independently (in their own homes) for as long as possible (Department of Health, 2003). Following on from the Acheson Report (1998) the government is prioritising the causes and consequences of health inequalities. This is reflected in the more recent white paper "Our Health, Our Care, Our Say" (Department of Health, 2006b). One of the main goals of this white paper is to 'do more on tackling health inequalities and improving access to community services' (p15).

Ealing have put together a number of policy and strategy documents, relevant highlights of which are given below.

Included in the 2004 document "Ealing's Strategy for Older People 2004-07" are the following visions statements concerning life in the borough

To make Ealing a safe, healthy and enjoyable place to live for older people, through the promotion of independence

All services will be person centred to meet people's diverse needs rather than people having to adapt to fit services

In 2006 the London Borough of Ealing produced "Growing Older, Growing Bolder – Ealing's Quality of Life Strategy for Older People and Carers 2006-16". Several of the strategic themes include aspects of health, housing and social care including:

- Healthy Lives – to encourage older people to be proactive, reduce health inequalities and social isolation
- Economic and environmental well being – including financial security, housing options, access to support services and a safe and pleasant living environment
- Active Engagement – to ensure older people are involved with planning, provision and the evaluation of services

The strategy aims to create innovative, co-ordinated and integrated services across the borough for older people and their carers. It echoes the emphasis on supporting older people at home and encouraging them to take more control of managing their own support.

It is evident that the local (Ealing) context includes a plethora of recent strategy, policy and best practice documents that can be summarised as prioritising the following:

- Addressing health inequalities
- Promoting independence and choice for older people
- Involving local BME communities in the planning and provision of services
- Ensuring better co-ordination of services to meet individual needs

3. Respondents information

This section includes information about the age, gender, religion, ethnicity, marital status and neighbourhood of those who were interviewed.

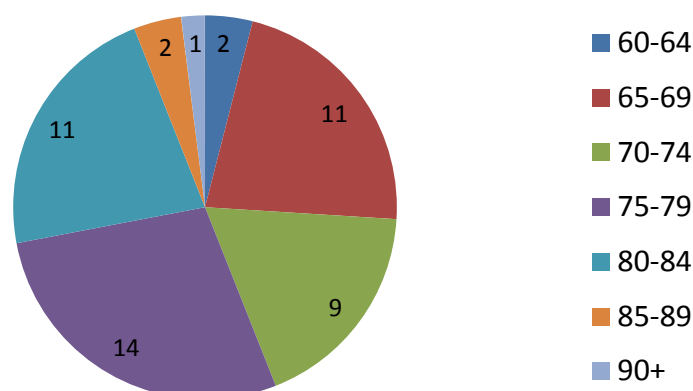
The interviews were conducted with 50 older people from the African and Caribbean community. Unfortunately there were no respondents from the Somali community, despite training two community researchers and making contact with two Somali organisations locally, participation was not forthcoming. The respondents came from: Acton, Ealing, Southall, Hanwell, Northolt and Greenford. There were no respondents from Perivale or West Twyford.

Table 1 Neighbourhood Area of Respondents

Area	Number
Acton	21
Ealing	12
Southall	6
Hanwell	6
Northolt	5
Greenford	1

The respondents were predominantly between the ages of 65 and 84 years (90%).

Figure 2 Age of Respondents



All respondents had come to the UK after the age of 16. Most had come as young adults aged 21 and over (72%), with the remainder arriving between the ages of 16 and 20.

There were 38 female and 12 male respondents. 45 of the respondents described themselves as being 'Caribbean' and 5 described themselves as 'African'. There were no respondents who described themselves as 'Somali' or 'African Caribbean'.

Almost all respondents aligned themselves with a religion and/or church (49 out of 50). Almost 50% identified themselves as 'Baptist' and a quarter as 'Church of England/Protestant'. 22% described themselves as 'Catholic'.

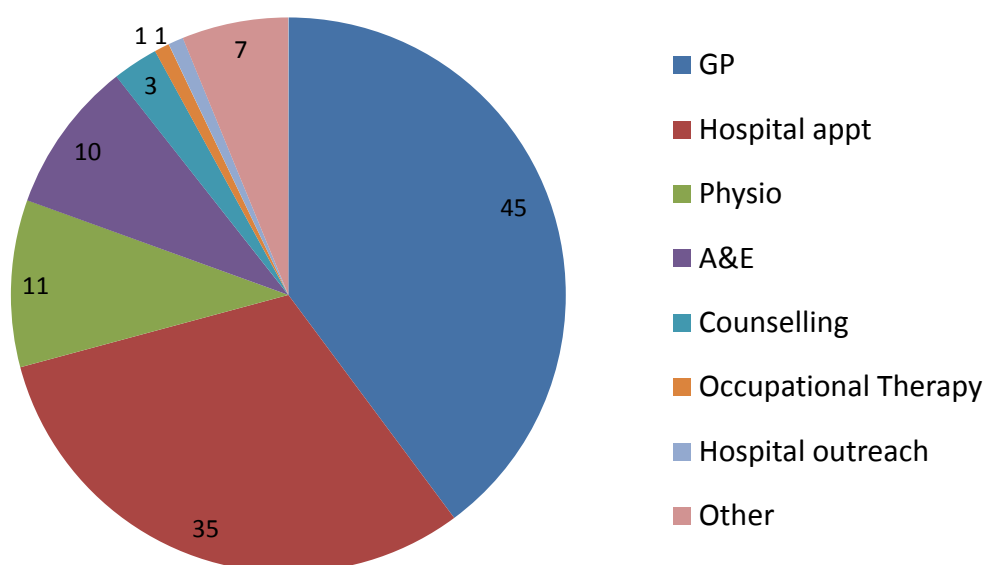
Out of the 50 respondents, 18 described themselves as 'married', 11 as 'single', 11 as 'widowed' and 10 as 'other'.

4. Understanding and Experience of Services

4.1 Health

Respondents could readily identify a number of health services. Almost all those interviewed had accessed health services during the past 2 years (48 out of 50). The first that came to mind were GPs and the outpatients department of the local hospital mostly related to ongoing health issues such as hypertension, diabetes or sickle cell anaemia. Other services that were regularly mentioned as relevant were; physiotherapy, occupational therapy and post-hospital care at home (see Figure 2).

Figure 2 Health Services Accessed in past 2 years



We asked respondents in the focus groups what 'good health' meant to them. A summary of their ideas is provided below.



We asked what experiences they wanted to share with us about the health services they had accessed. Many of the members of the focus group told us about their GP service. Many people had a good relationship with their family doctor and found the service trustworthy and reliable, easy to access and found that it gave them what they wanted in terms of referring on, medication or reassurances.

The services helped me because it helped me to overcome pain and I got advice on how to make my life more comfortable.

So far what I have got has been rapid and no time wasted.

They are on top of everything, I must admit I am well looked after, I hope it continues.

It's very good, I have a GP who doesn't make you feel as if you're causing a nuisance and is genuinely pleased when you are doing well. Wonderful!

Out of those interviewed, those who responded to the relevant question overwhelmingly reported that the service had helped them or their family (31 out of 36). In addition 29 out of 36 respondents rated the service they got as either 'good' or 'excellent'. The remaining 7 rated it as 'OK'.

However there were also a number of people reported examples of negative experiences within the service and this dissatisfaction generally related to; difficulties accessing the service and the negative attitudes of the health professionals.

- **Difficulties accessing the service**

Respondents talked about the change, over the last 10 years, in how they access the GP. Instead of being able to walk in for an appointment (as they reported it used to be), it is now necessary to telephone to make the appointment in advance. The focus group participants reported that this usually involves an answering service with recorded options before they get through to a receptionist. The receptionist then asks you what you need to see the doctor for, before allocating you an appointment.

You have to tell the receptionist what is the matter, they ask all the time, they want to know

They try and make it as difficult as possible, now you have to phone and listen to a recording, you can't always get an appointment

Years ago we would go along to the surgery, now the receptionist will ask what's wrong, I don't want to speak to the receptionist she's not the doctor

For the elders we spoke to this process was off-putting. In particular many people complained about having to reveal private health information to the receptionist in order to get an appointment, but feared that if they refused this may lead to a delay in getting an appointment. Some spoke of feeling like they were seen as 'time wasters'.

Once the appointment was gained, the respondents were mainly satisfied with the timing of this and waiting times at the GPs. Once in the room with the GP there were some concerns raised about the very limited time given to discussing health issues with the GP. Almost all the respondents liked to see the same GP every time and thought that this was important in terms of continuity of care and knowing their individual needs and experiences.

- **Negative attitudes & prejudice**

To some extent the attitude of the receptionist was reported to either encourage or discourage people in making an appointment, this was not based on any professional medical experience. When asked about how they thought their cultural needs were met by those in the medical profession, a number of respondents in the focus group concurred that the GPs didn't understand the elderly West Indian person's needs or culture and that they needed to in order to provide a good service. This was demonstrated by how the GP talked to them; one woman said that the doctor,

..would not touch me, he just writes. He doesn't listen to what I'm saying.

One respondent dealt with this in the following way;

I will not allow my doctor to not listen to me, but they will get away with it if you let them

Several respondents brought up the issue of lack of eye contact with the doctor who was usually 'just writing' and commented, 'they don't look you in the face'.

Even if the doctor was listening the impression given was that she/he wasn't paying attention to these patients.

In the focus groups the participants believed that being West Indian affected the service they received;

They don't understand the African Caribbean community, cultural differences, such as types of food. They don't know about it, what we like, we need to educate them.

Also some participants thought that doctors assumed they were ignorant and therefore they didn't spend time discussing and explaining issues to them. There was the generally held belief or assumption that the service was racist; that the service did not take into account their experience of life, including health issues such as higher risks of hypertension, diabetes and sickle cell anaemia.

4.2 Social Care

Not all members of the focus groups or interviewees had knowledge and experience concerning social care services. Less than half of those interviewed (38%) had personal experience of accessing social care services. This was mainly; domiciliary care, equipment for the home and self, and residential care. Only 17 of the 50 respondents were able to answer the question concerning the helpfulness of the social care services they received. Thirteen out of 17 had found the services 'helpful' and 3 out of 17 hadn't, one person was not sure. Only 15 out of the 50 respondents were able to rate the social care service they had received; 2 rated the services as 'excellent', 8 as 'good', 3 as 'OK' and 2 as 'poor'.

When focus group participants were asked what social care services they knew about there was less awareness of these services compared with the health services. Focus group participants were able to identify; meals on wheels, carers in your home after hospital, respite for carers, support with shopping and getting about, equipment such as stair lifts and hoists, mobility cars and walkers, as social care services. Correspondingly personal experience of social care services was more limited than experience of health services.

In the focus groups only statutory social services were discussed, despite the focus groups being led by a voluntary sector organisation (UACS) providing social care services. It is perhaps part of the experience of statutory social care services that they are considered 'other' or an add-on to 'normal' life; whereas voluntary sector provision if fully integrated into the community is not experienced as 'services' but as part of everyday life. All participants in the focus group and the interviewees would have some contact with UACS and many were being provided with social care services by them and/or some input from Age Concern.

We asked the focus groups what they understood by the term 'social care'. They said:



The focus group participants were asked to share their experiences of social care services. Some participants had not experienced these services, other participants were able to talk about their personal experience or what they had understood from the experiences of friends or relatives. It was more difficult to find any positive comments from the focus groups on this topic. There was a general feeling that social care services weren't for them and weren't much use. Particular issues that were raised included:

- Quality of home carers (domiciliary carers)

Some focus group participants talked about the difficulties they had experienced with carers;

They had no training and there was a different one every day. They were very arrogant and we complained

If you don't have a main carer, God help you. If you live on your own and have to depend on the carers – some of them (older people) are very frightened of saying anything about their carer.

You get all different types (of carer) – they can be extremely rough.

There was a real sense that older people from the African Caribbean community felt vulnerable to domiciliary carers. They didn't want to complain in case this had an impact on the service they already received or had unforeseen negative consequences. Even if they wanted to complain they were unsure how to and had not personal contact with a social service manager or social worker.

From a different perspective there were several people in the focus groups who had a more mixed view:

I have a carer, some are very good and some I don't want them to be there

If you get the right one it's very good

- **Negative attitudes and prejudice**

The focus group participants were asked how they thought the services met their needs, in particular the needs of their community. In response to this, the belief that everyone should get equal access to services was repeated across several focus groups. There was an implicit link made by the participants between difficulties accessing services and information about them and experiences of prejudice.

This was expressed as the need for each case to be assessed on its merits (level of need) rather than who shouts the loudest or who has the right colour skin;

*They're prejudice against black people, especially West Indian people.
Everyone says they are prejudiced, the way we're treated is wrong.*

You're assessed on how you look and how you talk not on your needs.

For some people the issue was knowledge about services - knowing what was provided and trusting that they were told about all the available provision. Although this was not expressed as an experience of prejudice in the groups; this lack of clarity about information and access was unlikely to dispel doubts and a sense of exclusion.

You don't always know what is on offer, I'm not sure if they let us know. Sometimes they don't know themselves or they don't tell us.

A further theme with respect to the experience of accessing services concerned the disclosure of personal information, and the fear and uncertainty that this can create.

You have to tell them from A to Z, and when you tell them everything about yourself, to try and get care, if you go wrong... then they can have you for fraud. So I don't go near it.

In my community people have saved and saved for things and they won't apply for fear of losing everything, so they don't go near it.

It should not be a book full of questions, just a few questions

Excessive questioning was seen as intrusive and unnecessary. There were concerns about losing out financially and about the repercussions should they accidentally get things wrong, this led to a number of people choosing not to engage in applying for services they might be eligible for.

There was more suspicion and less familiarity expressed when talking about social care services compared with the health services; this was partially explained by the more limited knowledge and experience concerning statutory social care services.

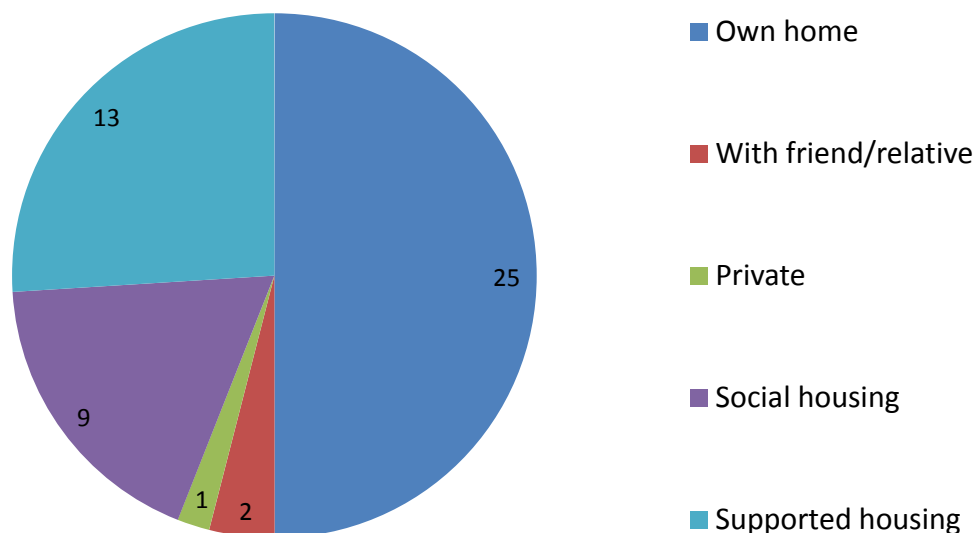
4.3 Housing

We asked interviewees what housing support services they had accessed within the last 2 years, 32% had not accessed any housing services at all in this period. Out of those who had, most commonly mentioned were; help with repairs and decoration and support/advice with housing bills and benefits. Some people also mentioned making their home safe, warm and accessible. Eleven out of the 50 respondents had accessed some form of support as part of their housing provision via either warden support or some form of 'floating' support.

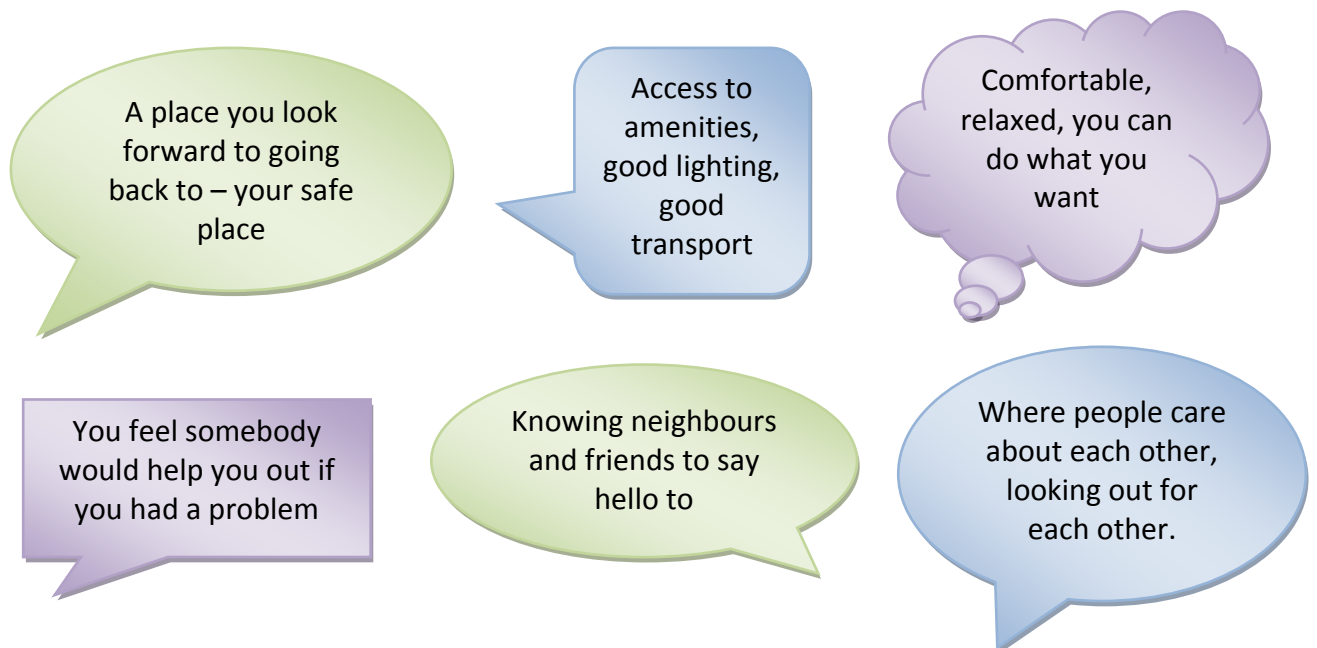
Out of the 50 respondents 21 answered the question concerning how helpful the service had been. 15 out of the 21 had found housing support services 'helpful', 3 weren't sure and 3 had not found them helpful. When asked about the quality of the support they were given 13 out of 20 rated the service as 'good' and 7 rated the services as 'OK'.

Exactly half of those interviewed were living in their own home and a quarter lived in some form of supported accommodation (see Figure 3 below).

Figure 3 Housing situation of interviewees



The focus group participants were asked what they thought made a house a home, and what made a 'good neighbourhood'.



Those in supported or sheltered accommodation were generally happy with their homes (Antilles House). They experienced the benefit of being able to access information about services available and how to access them from someone they knew and clearly valued this.

Because we're in sheltered, a lot of resources are put in through management. We go to a luncheon club and they have advisors to come in. You can find out from someone you know.

Despite the positive comments about housing services from those who had received them, people were somewhat unclear about their entitlements, the services available and the way to access these. Some of the more critical feedback in the focus groups was related to neighbourhoods and to the abovementioned difficulties accessing information and services.

- **Neighbours less neighbourly**

During the discussion about neighbourhoods a number of the participants stated their dissatisfaction with elements of their own neighbourhoods. Issues raised included neighbours being anti-social or unfriendly or unknown. Further to this several people commented on the deterioration of their neighbourhood referring to the attitudes of neighbours, instead of looking out for each other neighbours were inclined to ignore each other or be unhelpful.

Once this was a good neighbourhood, you would know the people next to you and they would say 'good morning'. Now they never say hello, they just go in, they leave rubbish by the doors, they couldn't care less.

People are jealous and miserable, they don't say good morning, they don't speak to you

However in contrast;

I have got a good neighbourhood, we have neighbourhood watch in our area. My neighbours look out for each other, they're watching to see who comes. Very lovely, I can't complain.

- **Difficulties accessing services**

In common with the social care experiences participants shared, some people's experience of trying to access housing services, such as housing benefits, was found to be highly intrusive, involving lots of personal questions about health and finances. This engendered feelings of exposure and vulnerability and put people off applying for housing support/financial support that they may be entitled to. One focus group participant talked about a relative;

They're still sorting it out, they won't give him any money unless he gives consent for them to look through his private affairs!

You need someone to represent you, you may not fill in the form right, you get better services if you are represented

Some people felt unable to access the service despite knowing about it:

I know what you can get but I can't get them

Entry into residential care or sheltered housing was similarly formidable but there was a level of support associated with it, usually provided by the housing provider.

When we first moved in there were lots of forms to fill out, council tax, benefits etc. But when it's done it's good.

5. Insights

This final section of the report highlights some of the insights gained by undertaking this research and explores the connections between themes.

- **Levels of discrimination**

It was found that many of the older African and Caribbean people we listened to believed the services and systems supporting them to be inherently racist and this permeated

through a number of levels; service design, service delivery and personal contact with people and processes.

Figure 4 Levels of discrimination



On a personal level people described contact with health professionals that left them feeling misunderstood, disrespected and without common or shared understanding of issues. The processes around accessing some services were off-putting to older people from African and Caribbean backgrounds (e.g. disclosing health information to receptionists). People we spoke to often had some fear of authority or of 'rocking the boat' due to their age and experiences, and were therefore unable to comment, complain or put forward a different perspective when services weren't meeting their needs. In addition many were unwilling to go through the process of disclosing personal and financial information to professionals they did not know. This process requires sufficient trust of authority and a degree of confidence that the professionals concerned have your best interests at heart.

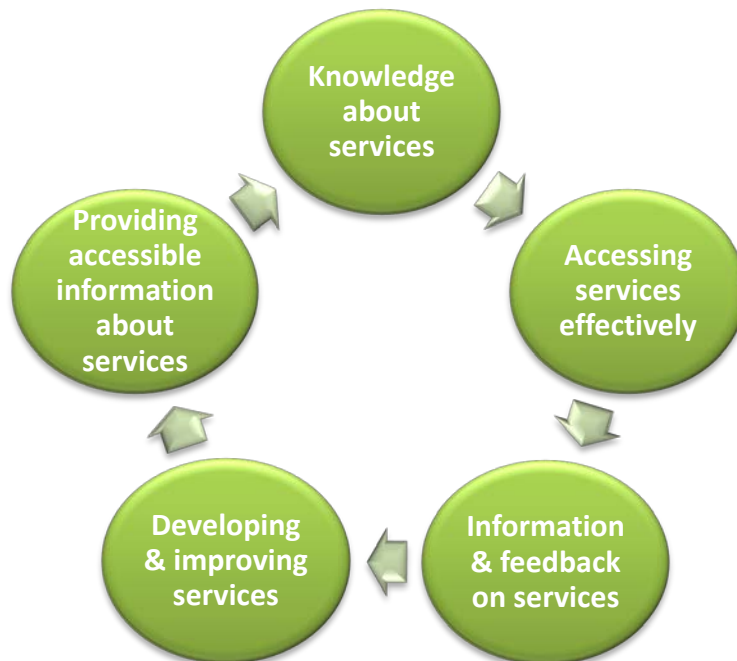
Those we spoke to believed that the way in which services were delivered did not regularly take into account the cultural and specific needs of African Caribbean older people; they had gained the impression that they had to fit in with the way services were designed and delivered. This experience may arise from a lack of involvement or ownership with respect to the ways in which services are delivered and managed. There was no evidence that any of the people we spoke to had contributed to the way in which services were designed and planned. They experienced the services on the basis of 'one size fits all'. This is not to negate some of the very positive experiences people also related during the interviews and focus groups.

What is more important than making sure services work for those they are supposed to work for? We question whether services and processes can operate effectively if they do not take into account the needs of the populations they serve? Involving African and Caribbean older people in decision-making about services and processes is likely to engage their support and engender improved relationships between service providers and the African and Caribbean community, as well as better outcomes.

- Cycles of information

One overriding theme arising from this study has been the need for more information; both on a direct and conscious level – knowing what services are on offer and how to access them, and on a subconscious level – internally questioning whether or not you are getting a good deal or all the information. People we spoke to were aware that they may not be aware of the availability of services or their entitlement to these! For example, eligibility criteria were not mentioned by any of the older people involved in this study. Making sure that everyone has sufficient accessible information about services and the processes involved in accessing them, promotes understanding and clarity and, may help to offset any sense of confusion or injustice.

Figure 4 Cycle of information



- Religion

Out of the 50 people interviewed 49 identified belonging to a particular religion; having a religion appears to be normal for this population. During the process of carrying out the research it has been clear that not only is it normal, but that it plays a large part in the lives of many African and Caribbean people's lives. Older people who spoke to us made frequent references to their religious beliefs including their faith in God and a sense of acceptance of what is and what will be in the future. Many people we spoke to had built their social and support network on the basis of the church they attended within the community. The

volunteer community researchers sought out particular churches in the knowledge that they would find a large proportion of older Caribbean and African people there to interview. Services, information and support provided through the church are likely to be enthusiastically accessed and generate a sense of ownership. The challenge for Health and Social Care services is how to take account of this factor in providing services for this group of people.

6. Recommendations

The recommendations are drawn from the responses given by those interviewed and from the participants in the focus groups; they also represent a suggested to-do list for the relevant health, social care and housing organisations to follow-up. We believe that these recommendations can go some way to overcome prejudicial attitudes and behaviours towards older people from African and Caribbean communities. Furthermore, we believe that a 'joined up' approach (i.e. Health, Social Care, the voluntary sector, churches and the communities working together) is needed to implement these recommendations.

6.1 Health Services Recommendations

Strategy and Review

- Develop a communications strategy to ensure that the African Caribbean community is involved and informed about services available, how to access them and their ongoing development.
- Maximise the use of voluntary sector agencies to distribute information about services and where appropriate to deliver them directly.
- Promote and raise awareness of healthy lifestyles targeted at this community.
- Inform and involve the local community in publicising information about services that are available and that they may be entitled to – a six-monthly booklet listing all the local health resources was suggested.

Systems and Processes

- Monitor and reduce waiting times for hospital appointments where possible, where not possible make it clear what the waiting times are likely to be and why.
- Develop a review system to ensure that any personal and health information recorded on IT systems is accurate and up to date.
- To encourage access to the GP provide the option of speaking to someone in person if using a recorded message/call centre.
- Allow GPs more time to listen and make an individual assessment of health needs, develop a double appointment system and encourage users to utilise this.
- Provide health information and service information on leaflets in a variety of public places in a variety of formats, not just via the internet.

Training & Development

- Provide training and information to improve awareness, knowledge and understanding of sickle cell anaemia and other common health issues in the African Caribbean community.
- Ensure GPs are trained to work with African Caribbean elderly community, aware of their health needs, cultural and religious beliefs.
- Reminder/refresher training for GPs and other health workers of the importance of good communication skills; eye contact, active listening and positive body language.
- Provide guidance for receptionists to ensure they do not ask for personal information on health status over the phone or in the surgery.

6.2 Social Care Services Recommendations

Strategy and Review

- Review and develop the system for accessing social care services (assessment and form filling) so that older people's privacy is not imposed upon unduly and to ensure that they understand why particular information is required.
- Monitor and review equal access to social care services, publicise the results within the community.
- Support opportunities, schemes, projects that encourage social interaction and connection amongst the elderly African Caribbean community.
- Develop a communications strategy to ensure that the African Caribbean community is involved and informed about services available, how to access them and their ongoing development. This might involve using voluntary agencies to inform and advocate about services or deliver them directly if this is appropriate.
- Develop closer working relationships with voluntary sector agencies and faith based organisations.

Systems and Processes

- Maintain continuity of carers so that relationships and trust can develop between carers and those cared for.
- Put in place a simple and trusted procedure for complaining or commenting on domiciliary care workers.

Training and Development

- Ensure social care professionals are trained to work with African Caribbean elderly community, including awareness of their care needs, cultural and religious beliefs.
- Ensure domiciliary carers are clear about their roles and tasks and that those they are caring for are also clear about what to expect of them.
- Provide training for domiciliary carers in working with African Caribbean community, ensuring familiarity with aspects of culture, religion and health needs.

6.3 Housing Services Recommendations

Strategy and Review

- Develop strategy to improve neighbour relations in the local community, including networks of support.
- Develop communications strategy targeted at the African Caribbean community to ensure the community is aware of what they are entitled to and the processes involved.
- Develop further housing options after consultation with the African Caribbean community e.g. bungalows, sheltered housing, floating support housing, retirement areas/villages.
- Review and inspect areas regularly to ensure good lighting and conduct safety audit.

Systems and Processes

- Channel relevant information about services through voluntary organisations that provide housing or other services for older people, particularly for the African Caribbean community.
- Have a transparent allocation process and eligibility policy for all housing services, simplify processes where possible, ensure advocates/advisors are available where required.

Acknowledgements with Thanks

John Swan for co-ordinating the project for UACS and to Sonny Takhar for commitment to seeing the project through and undertaking the focus groups and many of the interviews.

All the volunteers for their immense dedication, time, patience and good humour: Irma Charles, Harriet King, Julie Watson, Mary Ben-Nwagboso, Bethuel Masenya, Gillis Noel,

Frank Keating at Royal Holloway, University of London, for co-ordinating and keeping us all on track. Alix Walton for delivering the training with enthusiasm and Liz Hudson for getting all this started.

All participants from the community who gave their time and experience to answer our questions and share their experiences.

Stephen James at Ealing NHS Primary Care Trust for agreeing the funding for the project.

Have Your Say!

Identifying the Health, Housing and Support Needs of African and Caribbean Older People in Ealing – Literature Review

The aim of this literature review is to provide background to the Have Your Say! research project. Information for the review comes from both national and locally based research data concerning the health, social and housing needs of Black and Minority Ethnic older people in the UK. Where possible it draws on research concerning Black African, Black Caribbean and Somali older people in particular.

Section one of the literature review sets out the relevant demographic data available for the UK and, where available, for the London Borough of Ealing. Section two outlines the national frameworks for the provision of services related to health, social care and housing needs, as well as the appropriate local frameworks and guidance. The third section sets out what we know and what we don't know about the needs of Black and Minority Ethnic older people and in particular (where possible) the needs of Black African, Black Caribbean and Somali communities. For clarity this section is divided into needs concerning a. Health, b. Housing and c. Social Care, however it is acknowledged that these areas and the needs associated with them overlap and are frequently interrelated.

1. Demographic Information

The 2001 Census indicates that between 1991 and 2001 the general population of the UK has risen from 57.5 million to 60.2 million. The proportion of the population who are older people (over 65 years) has risen from 13% to 16%. In this same period the proportion of the population from black and minority ethnic backgrounds has risen from 6% to 9%. The total population of Black and Black British people in England stands at 1,132,508 or 2.3% of the population; for those defining themselves as 'mixed' the figure is 643,373 or 1.31% of the population. The Black or Black British category in the 2001 Census is made up of Black Caribbean (50%), Black African (42%) and Black Other (8%) (Katbamna & Matthews, 2007). In their study Katbamna and Matthews (2007) explore the age structure of the population, identifying a 'middle-age' heavy Black and Black British population – with the majority of this population in the 30 -50 years category. This same population will now be approaching the 40 – 60 years category.

For the London Borough of Ealing the overall population is approximately 300,000; people over the age of 65 make up 11.6% (34,000) of this figure. More than 40% of the general population in Ealing are from Black or (none-white) minority ethnic communities – with 25% identifying themselves as Asian or Asian British. 8.8% of the local population identify themselves as 'Black British' and 3.6% of the population consider themselves to be 'Mixed Race'. The London Borough of Ealing is the fourth most diverse local authority in the country.

We do not have data concerning the numbers or proportions of African, Caribbean or Somali people over 60-65 years.

The Somali community in Ealing has grown within the last 10 years due to the arrival of refugees, Somalis make up 29% of the local refugee population (LB Ealing, 2005b) and somewhere between 3-10% of the total population (ibid).

It has been estimated that by 2011 28% of Ealing's older people will be made up of BME people, within this 7.5% of Ealing's older population will be from African, Caribbean or other Black communities (Ealing PCT, 2006). The age profile of the Caribbean population in Ealing is older than that of African (LB Ealing, 2005b).

Like other London boroughs Ealing includes pockets of affluence and pockets of high deprivation (for example, Southall and Acton); within the deprived neighbourhoods live a high proportion of the BME population. The African-Caribbean community are concentrated in Acton and the northern wards of the borough (Ealing, 2005b).

2. Overview of current national and local frameworks and guidance

National

In 2001 the Department of Health set out the first comprehensive strategy to ensure fair, high quality integrated health and social care services for older people in the "National Service Framework for Older People"; this outlines a ten year action plan. One of the key principles of the strategy and plan is that the

"NHS will respond to different needs of different populations, also shape services around the needs and preferences of individual patients, their families and their carers."

A continuous and overarching theme of local and national frameworks and guidance since this time has been to promote the ability of older people to live independently for as long as possible (Department of Health, 2003). Following on from the Acheson Report (1998) the government is prioritising the causes and consequences of health inequalities. This is reflected in the recent white paper "Our Health, Our Care, Our Say" (Department of Health, 2006b). One of the main goals of this white paper is to 'do more on tackling health inequalities and improving access to community services' (p15).

It is well established that people who are less affluent have higher mortality rates from nearly all the major causes of death. Other factors affecting mortality rates include; social class, ethnic group and geographical area. There is therefore a recognised need for services to be proactive in promoting access to services, including through the use of outreach support to relevant groups to ensure equity of access (Department of Health, 2006b). The white paper also sets out a new funding stream - POPP (Partnerships for Older People Projects). This is ring-fenced funding for the development of a series of pilot projects that

will shift resources and approaches towards the prevention end across both health and social care. The desire to encourage people to take control of their health care services via individual budgets is also highlighted in this document – with particular reference to older people.

London Borough of Ealing

The main themes from a plethora of recent strategy, policy and best practice documents (see references) include:

- Addressing health inequalities
- Promoting independence and choice for older people
- Involving local BME communities in the planning and provision of services
- Ensuring better co-ordination of services to meet individual needs

Included in the 2004 document “Ealing’s Strategy for Older People 2004-07” are the following vision statements concerning life in the borough

“To make Ealing a safe, healthy and enjoyable place to live for older people, through the promotion of independence”

“All services will be person centred to meet people’s diverse needs rather than people having to adapt to fit services”

In 2006 the London Borough of Ealing produced “*Growing Older, Growing Bolder – Ealing’s Quality of Life Strategy for Older People and Carers 2006-16*”. Several of the strategic themes include aspects of health, housing and social care including:

- Healthy Lives – to encourage older people to be proactive, reduce health inequalities and social isolation
- Economic and environmental well being – including financial security, housing options, access to support services and a safe and pleasant living environment
- Active Engagement – to ensure older people are involved with planning, provision and the evaluation of services

The strategy aims to create innovative, co-ordinated and integrated services across the borough for older people and their carers. It echoes the emphasis on supporting older people at home and encouraging them to take more control of managing their own support.

3. Identified Needs of Older People – National and Local

Whether we are talking about health, housing or social care an overarching need for BME older people is the need for **information** in terms of; awareness of it, availability, quality, accessibility, appropriateness and relevance to the community (Zahno & Rhule, 2008). Whether the provider is simply designing an information leaflet or implementing an

information strategy careful consideration is required for this to have an effective impact on the BME older population. Some of the factors that need to be considered are identified by Zahno and Rhule (2008):

- Language – translation and other formats, not all communities are literate
- Terminology – ensure meaning is accurate and appropriate
- Media – what is the most appropriate vehicle for the information and community
- Informing choices – inform a choice rather than simply signpost
- Culturally appropriate – this should be tested out before launching
- Part of a strategy – fit into local strategy and co-ordinate with other actions
- Involving – offering choices rather than telling people what to do
- Outcome orientated – what are the outcomes for all stakeholders

As part of improving the quality of life for Ealing’s population of older people a number of consultation events and meetings took place to inform the strategy within “Growing Older, Growing Bolder” (Ealing, 2006). These aimed to identify potential problems and areas for improvement as highlighted by the local community by asking:

What was important to them
How current services could be improved
What we need to do differently
What new services are needed
How they wanted to continue to be involved in development, monitoring and delivery of services

Six top priorities emerged from the responses:

1. More co-ordinated approach to transport provision
2. More co-ordinated multi-agency approach to the prevention agenda including, health, social care and leisure, housing and education.
3. The development of more social outreach and support services, especially amongst BME communities
4. More work on general information provision including; falls prevention, continence, good nutrition and healthy eating, social activities and respite care.
5. Development of social outreach services especially promoting emotional well being, activities for care home/sheltered residents
6. Improving customer engagement in planning and delivering services

From these priorities a number of objective were set, those of particular relevance to this study are: to increase the numbers of hard to reach groups accessing services. This objective includes:

- the provision of exercise programmes in Acton and Southall especially for BME communities and;
- a home library service in partnership with the voluntary sector and community groups;
- outreach support to carers of Asian older people;

- ‘Reaching out to communities’ project including advice on services to Afro Caribbean communities;
- Establish ‘Reaching out to communities’ with Somali community including recruitment of a Somali outreach worker;
- Floating support service to older people in BME communities in their own home;
- Undertake research and planning consultation regarding accommodation and support to live at home for the BME older population.

a. Housing Issues

Ongoing research carried out by JRF (Joseph Rowntree Foundation) identifies a persistent lack of recognition of the circumstances of BME individuals and communities and that these are often ignored in policy and practice responses (Ealing, 2005, BME Housing Strategy). Indeed local documents suggest that there is limited knowledge of the housing needs and choices of BME older people in the local community (Ealing, 2007 – housing strategy for older people; Ealing, 2005 – Supporting People). In the strategic development of housing services the need to map current and future needs of the ‘increasingly diverse elderly population across tenure’ is recognised (Ealing, 2007). The majority of older people living in Ealing are claiming income support and over half of the older people live on their own (Ealing PCT, 2006).

The other key strategies outlined in Ealing’s most recent “Housing Strategy for Older People” are; providing homes that meet the diverse older population’s needs now and in the future; promoting independent living and; healthy well-being through the delivery of effective housing related support services that reduce the need for residential and nursing care. Improving the quality of homes inhabited by older people and their energy efficiency are also part of this strategic plan, as are plans to increase the level of ‘floating support’ services available to older residents; in order to increase the number of older people supported to live independently at home by 12% by 2016.

In terms of need, during the past 10 years demand for social housing in the borough has outstripped supply, exacerbated by house price rises and the Right to Buy legislation. Currently 18% of those in social rented accommodation are Black African or Caribbean. Overall BME groups represent 75% of the housing register in Ealing and make up 66% of those on the transfer list. Homelessness (across all age ranges) disproportionately affects BME communities making up 45% of homeless acceptances and 80% of those seeking Housing Advice (during 2002-03). In particular 23% of the older people accepted as homeless are African. The council are aware that choice over housing provision can be affected by discrimination or purely on difficulties faced. It is also acknowledged that information on housing options needs to be more accessible (Ealing, 2005 – BME Housing Strategy; Zahno & Rhule (2008)).

What Ealing wants to do in the future: (taken from Supporting People Strategy 2005-10 p49)

- *Commission through the housing service a comprehensive study to map housing needs, targeting Black Minority Ethnic (BME) communities, community leaders and users of services.*
- *Assess the condition of housing amongst a cross-section of BME groups. (This work has been undertaken for the private sector including Registered Social Landlords and is still being progressed for the local authority stock.)*
- *Ensure that Supporting People is reflected in the BME Housing Strategy.*
- *Examine opportunities for the additional commissioning of ethnic specific service providers to develop housing-related support services as identified in the Supporting People review process.*
- *Continue to work with commissioning managers and providers to identify BME housing support needs.*

Some of the needs and difficulties identified in Ealing's "Black and Minority Ethnic Housing Strategy Needs Analysis 2005" are:

- Language barriers and accessible interpretation services – particularly with the elderly
- Staff lacking specialist knowledge and understanding in areas where BME groups need most support
- Importance of face to face or personal contact with services
- Ability of Black households to access housing tenure of their choice
- High levels of overcrowding on the whole
- Growing level of homelessness among Black households
- Meeting the housing needs of Somali community members in terms of culture and refugee status

Research evidence indicates that the mainstream response has been to emphasise the provision of sheltered schemes targeted at particular ethnic groups, rather than addressing housing needs within existing housing or meeting the need for extra care. Thereby not meeting the needs or aspirations of the diverse population of older people (REU, 2008 – Meeting Sheltered and Extra Care ...).

Key issues emerging from recent research on the housing needs of BME older people nationally are similar to those found locally and include:

- Lack of awareness or understanding among BME elders of the housing options
- Lack of appropriate promotional material

- Lack of understanding of the specific cultural and/or religious needs of BME elders
- Lack of staff with appropriate language skills or cultural knowledge
- Location of housing schemes inappropriate or inconvenient
- Inappropriate design of accommodation
- Assumptions made by service providers
- Need to involve BME elders in service development process

(REU, 2008)

Solutions to these needs and issues are offered in the report “Meeting Sheltered and Extra Care Housing Needs of Black and Minority Ethnic Older People” (REU, 2008) and included; further research and monitoring; employing appropriate staff and providing training; involving BME communities as service providers or as part of the service development process; raising awareness of available services and ensuring cultural and religious requirements are specified at the point of service design and delivery.

The local housing context in Ealing includes 9 providers that provide BME housing support specifically and a further 5 providers who target some of their housing support at BME clients. In total 37 BME housing support schemes provide support to 386 individual clients (Ealing, 2005 – Supporting People). Further analysis of the figures identifies that there are no targeted services for BME learning disabled older people, and few for homeless people. However there are 11 service providers catering for BME older people with support needs providing a service for up to 198 clients. A priority for housing in Ealing is to ensure that services address unmet needs, and the remodelling or addition of services to meet these – of particular relevance is the inclusion of older people with dementia or mental health problems (Ealing, 2005). The expansion of floating support services in order to provide support for people to remain in their own homes independently continues to be seen as key.

The Supporting People Strategy (Ealing, 2005) identifies that 50% of people receiving accommodation based services are older people. Extensive consultation and a needs analysis conducted to feed into this report shows an undersupply of services for the frail elderly and older people with mental health problems or dementia. There is also an undersupply for Somali refugees (not known what proportion of these may be older people) (Ealing, 2005 – supporting people strategy 05-10). This strategy too, identifies the need for further research to establish the needs of Black and Minority Ethnic populations.

b. Health Service Issues

In terms of health inequalities research shows that the gap in life expectancy is large and has been growing since the 1970s. For example; by the early 1990s the mortality rate amongst ‘unskilled’ groups in the population was 3 times higher than that for ‘professionals’; some parts of the country have the same life expectancy as the national average in the 1950s. Continuing this trend the ‘inverse care law’ often applies – that is the people who are in greatest need tend to have poorer access to poorer quality services (Department of Health, 2006b). Unsurprisingly health inequalities disproportionately affect the BME population; they are more likely to live in the poorest 20% of the local authority

areas; they more often have difficulties accessing services that tend to be of poorer quality and are not responsive to their needs (ibid).

In the recent report by the Department of Health and Healthcare Commission (2008), that identified how patients from black and minority ethnic groups experienced healthcare, Black patients were (on the whole) less positive about their care and treatment in outpatient, emergency and PCT settings than White British patients; but were more likely to be positive about community mental health care than other ethnic groups. Other particular patterns emerged from the surveys – BME patients were less positive in their responses to questions about ‘access and waiting’ relative to the White British group and were less positive in their response than the White British group when asked questions from the domain concerning ‘better information, more choice’. The BME patients were more likely to say that ‘staff talked in front of them as if they weren’t there’ than the White British group. A range of factors and explanations for these differences, such as expectations and differing perceptions with respect to both the services and the survey itself, may account for these differences. Geographical location may also play a part if BME groups are located in specific areas. However the findings are an indicator that health services can improve with respect to providing for BME patients.

Within Ealing the disparity in health within local geographical areas is strongly in evidence. There are health inequalities with respect to life expectancy, permanent sickness/disability and coronary heart disease. The prioritisation of health inequalities nationally has been implemented locally by the targeting of resources and information within the areas of highest deprivation. The impetus to reduce health inequalities is a theme running through a number of key strategic local documents (LSP for 2003; Ealing’s Local Neighbourhood Renewal Strategy 2002; Ealing Community Safety Strategy 2005; and Ealing PCT’s Local Delivery Plan for 2005).

For older people the most common type of disabilities identified are those affecting locomotion and also hearing impairment. Applying the 2001 Census data to prevalence rates for dementia identifies approximately 2,300 older people locally, more than 1,500 of these are over the age of 85. During 2005/6 data gathered indicates that there were 11,740 attendances of people over 65 at the Accident and Emergency Department of Ealing Hospital, 46% of these were discharged without any medical follow-up (Ealing, 2006 GOGB).

In Ealing the most common type of disabilities affecting older people are mobility related and/or hearing impairment. The prevalence of dementia is 20% in those aged 80 plus (Ealing, 2007 – Housing strategy for older people). Other issues identified, as relevant to supporting older people to maintain independence through good health, are the importance of accident and falls prevention and the efficient provision of aids and adaptations to improve home safety.

In terms of the recent local health audit almost all minority ethnic groups reported higher levels of limiting long term illness (except Chinese). It is important to take into account the increased health risks and rates among the BME communities. For African Caribbean people there is a prevalence of cardio-vascular disorders (including hypertension and stroke), respiratory disorders and arthritis compared with the general population. This population are also 5 times more likely than the White population to develop non-insulin dependent

diabetes (Ealing, 2006 – JSNA, Department of Health, 2001 – NSF). Black Africans are the most likely group to be affected by tuberculosis (TB). All of which will lead to an increased risk of dependency on others for care and support, at an earlier age than the general population. Information concerning mental health indicates that although levels of depression appear to be broadly similar when comparing Caribbean elders with their White counterparts, one study suggests that for the Caribbean elders this is associated with lack of social contact and feelings of isolation, more so than for the White elders (McCracken et al, 1997).

Research on the health issues for refugees and asylum seekers by The Refugee Council emphasises the importance of health provision being culturally appropriate and in their home language (Refugee Council, 2006). Additional needs for both young and old refugees and asylum seekers are dealing with loss and post-traumatic stress disorder. A report by South London and Maudsley NHS Trust identifies that although older refugees with such conditions would benefit from psychotherapy language problems prevent this from being provided (South London and Maudsley NHS Trust, 2001).

In response “Ealing’s Health Inequalities Strategy 1005-10” has adopted 4 themes to guide their local strategy to end health inequalities:

1. Addressing the underlying determinants of health
2. Preventing illness and providing effective treatment and care
3. Engaging communities and individuals
4. Supporting families, parents and children

(Ealing, 2005 – Health Inequalities Strategy)

The strategy recognises the difficulties of access for the BME communities and the relative lack of relevant available services for them. Therefore part of its action plan includes the engagement of BME groups to ensure services are appropriate to need. This reflects best practice identified in the National Service Framework for Older People (Department of Health 2001) that stresses the importance of involving older people, and those who are representative of the local community, with planning and evaluating services. In addition health promotion activities need to take into account the impact of cultural and religious beliefs (Department of Health, 2001 – NSF). The action plan also identifies the link between health and housing and includes action to gather information on housing support needs from the BME groups, collate and disseminate findings to stakeholders.

In a recent white paper “Our Health, Our Care, Our Say – A new direction for community services” (2006) overriding issues for service users included:

- Transport Issues; the need for better transport for older people needing to access health and social care provision. The white paper envisages national standards for patient transport and to increase the field of people eligible for it.
- Isolation; a further problem for older people recognised by the white paper is the need to tackle loneliness and isolation.

- Information; health information needs were identified across the whole population; more and better quality information would help people to feel more in control of their health and well-being.

Themes from *local* consultation by Ealing Primary Care Trust highlight the need for;

- better co-ordination between agencies;
- more support for minority ethnic communities;
- more support for housebound people;
- better health information;
- improvements in transport and
- greater involvement of people in planning local services.

(Ealing PCT, 2008).

c. Social Welfare Issues

According to the Age Concern Report (Zahno & Rhule, 2008) concerning information and advice for BME older people “one of the most important issues to them (BME focus group participants) is a greater awareness of their entitlements to social care...”. The report recognises the importance of linking BME older people into services which specialise in the entitlements of older people. It states that for BME people over 60 years of age there is a lower take up of health and social services than their White counterparts. Local community organisations play a very important role in supporting access to social care provision for BME communities. Although care may be provided by informal cares within the family or BME community this is not necessarily the case; when it is the case there is a lack of support and a sense of isolation. For BME carers this is exacerbated by lack of appropriate service provision, difficulties accessing information and advice, greater levels of poverty, poor housing and racism (Gunaratnum, 1990).

Approximately 5.5k older people are being supported by Ealing adult social services provision, 20% of these are living in residential or nursing homes and 80% are accessing community based services in their homes (Ealing PCT, 2008). In terms of those known to social services these include:

- 92% of those over 90 years old
- 36% of those over 85
- 24% of those over 80

(Ealing, 2006 – GOGB)

Over recent years there has been a steady rise of older people accessing social care services in Ealing. From a 24% increase from 2002 to 2003 and a 52% increase from 2003 to 2004 to a 41% increase from 2004 to 2005 (Ealing, 2006 GOGB).

People over the age of 80 make up 60% of all adult services provision. Most commonly requested services by older people are; homecare (41%), occupational therapy equipment (13.3%) and domestic help (6.3%). People from BME communities are over represented in terms of referrals to support services. All Black groups account for 30.4% of the new service

users compared with only 8.8% of the local population, with Black African 16% and Black Caribbean 10.9% (Ealing, 2005 – Supporting People Strategy)

Needs identified within the recent Ealing JSNA (Joint Strategic Needs Assessment) 2006 included: service information especially for isolated and minority ethnic older people involving; outreach work, a directory of services and relevant news, updates distributed locally.

The Quality of Life Strategy highlights the case for improving the number of people claiming and receiving benefits where they are entitled, and to direct people towards financial advice services that enable them to make use of their asset. In Ealing key actions include to provide financial assistance and advice services to ensure the effective take up of benefits and improve financial management. (Ealing, 2007 – Housing strategy for older people).

“It was an uncomfortable fact but, directly or indirectly, mainstream services and mainstream society were still seen by the older people in the groups as being both ageist and racist. They said it was impossible to ignore this fact and it needed to be said”.

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**Identifying the Health, Housing and Support Needs of
BME Older People in Ealing**

A Research Study

Interview Schedule for BME Older People

**Department of Social Care
Royal Holloway,
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Egham, Surrey, TW20 0EX
Tel: 01784 414964**

A. Introduction and Personal Information Section

This survey is to explore your views and experiences of the health, housing and other services that support you to live your life on a daily basis (social care services e.g. meals on wheels, home help, day centres). We want to find out about what services you have used and what these were like for you. Your views and experiences will help inform those who run services in the Ealing area and promote the needs of older people to them.

Time and Date of interview _____

Interviewer _____

1. Name (optional):

2. Age – check if born 1950 or before then check exact age or range below:

- 1 60-64
- 2 65-69
- 3 70-74
- 4 75-79
- 5 80-84
- 6 85-89
- 7 90 plus

Age: _____

3. Gender:

- 1 Female
- 2 Male

4. Ethnicity – how would interviewee describe themselves:

- 1 African
- 2 Caribbean
- 3 African-Caribbean
- 4 Somali
- 5 Black British
- 6 Other _____

5. Whereabouts in Ealing do you live? (either area or postcode is fine)

- 1 Ealing
- 2 Acton
- 3 Hanwell
- 4 Southall
- 5 Greenford
- 6 Northolt
- 7 Perivale
- 8 West Twyford

Post Code:

6. a. How long have you been living locally?

- 1 less than a year
- 2 between 1-5 years
- 3 more than 5 years _____(indicate how long)

b. How long have you been living in the UK?

- 1 born in UK
- 2 Came here as a child
- 3 Came here as a young adult (16-21)
- 4 Came here as an adult (over 21)

7. Can I ask you if you would describe yourself as:

- 1 married
- 2 single
- 3 widowed
- 4 other_____

8. Can you tell me how you would describe your religion?

- 1 No religion
- 2 Catholic
- 3 Church of England/protestant
- 4 Muslim
- 5 Other_____ (Jehovah's, 7th Day Adventist etc)

B. Social Care Section

I'D LIKE TO START OFF BY ASKING YOU ABOUT ANY PREVIOUS EXPERIENCE YOU HAVE OF WHAT WE CALL SOCIAL CARE SERVICES – THAT IS SERVICES TO HELP YOU WITH YOUR DAILY LIFE – SUCH AS HOME HELP, MEALS ON WHEELS, DAY CENTRES – THINGS LIKE THAT

9. a. **Do you think you have you had any of these kinds of services recently (in the last 2 years) and can you tell me about them?**

Use own words then code (or prompt if not sure):

- 1 None
- 2 Domiciliary care – help or care in your own home
- 3 Respite for cared for person – a break from caring for someone
- 4 Day centre offered
- 5 Referred to another service such as health, voluntary sector, housing
- 6 Equipment for the home
- 7 Equipment for self – hearing aid, walking aid
- 8 Social worker visits (support and information)
- 9 Meals on wheels
- 10 Residential place
- 11 Other _____

b. If Yes, note when the last contact occurred

- 1 Within the last month
- 2 Between 2 & 6 months ago
- 3 Between 7 & 12 months ago
- 4 Between 13 & 24 months ago
- 5 Not sure/don't know

DATE _____

c. Do you know what (other – if 'yes') services like these are available locally (social care) and how to access these?

- 1 No
 - 2 Yes
 - 3 Somewhat (use own words) _____
- _____

**10. What was it that you needed or wanted help with from this service?
(use own words - then categorise or clarify with prompts)**

- 1 Independence needs – general or due to frailty
- 2 Learning disability
- 3 Mental health needs
- 4 Illness/physical disability
- 5 Carer needs (interviewee is a carer)
- 6 Safeguarding needs (interviewee was at risk)
- 7 Sight or hearing problems
- 8 Other needs _____

11. Do you know which team/service/department worked with you/supported you mainly?

- 1 Yes _____
- 2 No

If yes, who/which? (any information about name of team, location or contact details)

12. a. Do you think this service or support helped you or your family?

- 1 Yes
- 2 No
- 3 Not sure

If yes, how?

Use person's own words

b. What did you think of the service you got – how would you rate it? (use person's own words, then rate – or ask them to rate if unsure)

- 1 Excellent – very effective/high quality
- 2 Good
- 3 OK
- 4 Poor
- 5 Very poor – very ineffective/low quality

13. Can you say anymore about anything that you really liked or disliked about the service or support you got? (prompt e.g. access, understanding your needs, discrimination, quality of care, attitude of staff)

If yes what was this?

a. Liked

b. Disliked

14. Was there anything else that you wanted help with but didn't get it?

- 1 Yes
- 2 No
- 3 Not sure

If yes what were/are these?

C. Housing and Accommodation Section

NOW I'D LIKE TO ASK YOU ABOUT HOUSING AND ACCOMMODATION SUPPORT SERVICES – SUCH AS ADVICE OR HELP ABOUT MAKING YOUR HOME SAFER, MORE SECURE, CONSERVING ENERGY OR MAKING CHANGES TO YOUR HOME, OR ANTHING ELSE LIKE THAT.

15. Can you say what sort of accommodation you currently live in?

- 1 Living in own home (owned by interviewee)
- 2 Living with friend or relative in their home
- 3 Privately rented (by interviewee)
- 4 Council or social housing association tenancy
- 5 Supported accommodation (either floating or warden support)
- 6 Other_____

16. a. Have you had any support or help to do with accommodation recently (in the last 2 years) (prompt using some examples below if not able to say) and what was this for?

Use own words (or prompt with list below):

- 1 Support and advice with housing bills and benefits
- 2 Support and advice making your home safe (burglars, fire, H&S)
- 3 Support and advice making your home accessible for you
- 4 Help with repairs and decoration
- 5 Help making decisions about the right housing for you
- 6 Have floating support
- 7 Have warden support
- 8 Other_____
- 9 No support

b. If YES when was this?

- 1 Within the last month
- 2 Between 2 & 6 months ago
- 3 Between 7 & 12 months ago
- 4 Between 13 & 24 months
- 5 Not sure/don't know

DATE_____

If YES or NO

c. Do you know what (other – if ‘yes’ to above) housing support services are available locally and how to access these?

- 1 No
 - 2 Yes
 - 3 Somewhat _____
-

If YES

17. Do you know which team/organisation/department worked with you/supported you mainly?

- 1 Yes
- 2 No

If yes, who/which? (any information)

18. a. Do you think this service or support helped you or your family?

- 1 Yes
- 2 No
- 3 Not sure/don't know

If yes, how?

Use person's own words

b. What did you think of the service you got – how would you rate it? (use person's own words, then rate)

- 1 Excellent – very effective/high quality
- 2 Good
- 3 OK
- 4 Poor
- 5 Very poor – very ineffective/low quality

19. Was there anything in particular that you really liked or disliked about the service or support you got? (give time then prompt e.g. access, understanding your needs, discrimination, quality of care, attitude)

If yes what was this?

c. Liked

d. Disliked

20. Were/are there any issues or problems that you didn't get help with but wanted to?

- 1 Yes
- 2 No
- 3 Not sure

If yes what were these?

D. Health and Emotional Well-Being Section

NOW I'D LIKE TO ASK YOU ABOUT YOUR HEALTH NEEDS – HOW YOU FEEL PHYSICALLY AND YOUR EMOTIONAL WELL-BEING AND HAPPINESS

21. a. Have you had any contact with any health services in the last 2 years, and what sort of service was this/what happened – can you tell me about this?

Use own words then code (tick more than one if needed):

- 1 GP
- 2 Hospital – A&E service
- 3 Hospital – appointment for checks/specialist input
- 4 Hospital – outreach or follow-up in own home
- 5 Practice nurse
- 6 Occupational therapy
- 7 Physiotherapy
- 8 Counselling/psychotherapy/psychiatry
- 9 Other _____

If NO go to 19c

- b. If Yes, note when the last contact occurred (if more than one list write which type next to code and/or list as 1st, 2nd etc)

- 1 Within the last month
- 2 Between 2 & 6 months ago
- 3 Between 7 & 12 months ago
- 4 Between 13 & 24 months ago
- 5 Not sure/don't know

DATES _____

- c. Do you know what (other – if 'yes') health and well-being support services are available locally and how to access these?

Use own words (then code over page):

- 1 No
- 2 Somewhat _____
- 3 Yes

22. Do you know which team/organisation/department worked with you/supported you mainly?

- 1 Yes _____ (name, details)
- 2 No

23. a. Do you think this/these service/s or support helped you or your family?

- 1 Yes
- 2 No
- 3 Not sure/don't know

If yes, how?

Use person's own words

b. What did you think of the service you got – how would you rate it? (use person's own words, then rate. If more than one service list a,b,c, etc)

- 1 Excellent – very effective/high quality
- 2 Good
- 3 OK
- 4 Poor
- 5 Very poor – very ineffective/low quality

24. Was there anything in particular that you really liked or disliked about the service or support you got? (prompt e.g. access, understanding your needs, discrimination, quality of care, attitude)

If yes what was this?

a. Liked

b. Disliked

25. Were/are there any issues or problems that you didn't get help with but wanted to?

1 Yes

2 No

3 Not sure

If yes what were these?

WE'VE TALKED ABOUT SOCIAL CARE SERVICES, HOUSING AND HEALTH SERVICES AND WHAT YOU THINK ABOUT THEM. I'D LIKE TO ASK ABOUT ANY FURTHER OR FUTURE NEEDS YOU HAVE THAT WE HAVEN'T TALKED ABOUT...

26. What do you need to improve your life on a daily basis now?

27. What do you think you might need over the next few years?

28. Finally what do YOU think should be the priority for funding with respect to;

a. Social Care _____

b. Housing _____

c. Health (inc. Mental health)

(prompts; home based services, community based services, social, specific needs, centre based facilities, expertise and advice, support,)

MANY THANKS FOR YOUR TIME AND VIEWS, THESE WILL BE USED TO INFORM THE DEVELOPMENT OF LOCAL SERVICES.

Focus Group Schedule: UACS/RHUL Research Project

Introduction

1. Ensure that the participants understand why they are there and introduce the research. Main objectives/purpose and what the information will be used for. These are covered on the introduction at the top of the interview schedule, but can elaborate further as necessary.
2. Gain consent verbally – ensuring everyone happy to participate and willing for information to be used for research project anonymously.
3. Explain discussion group/focus group format will involve them talking to one another about the questions you raise and sharing their ideas, opinions and experiences.

ALLOW 5-10 MINUTES

Questions

1. **Warm-up Question** (the aim of the question is to get people talking and thinking widely about the topic – choose a, b, or c depending on the topic you are addressing)
 - a. Social Care: what is your understanding of this term ‘social care’ and what services do you think it does or should include?
 - b. Health: when we say ‘I’m healthy’, ‘in good health’, what do we mean by this, what makes us feel healthy?
 - c. Housing: what makes a house a ‘home’ or where you live a ‘good neighbourhood’

ALLOW 10 MINUTES

2. **Main Questions** (to explore and dig deep on the central issues) – focus on either social care, health or housing.
 - a. What is your experience of accessing these services and what do they have to offer you?
 - b. What works well at the moment, what services or support are really helpful and effective?
 - c. What is it about these that you value?

ALLOW 20 MINUTES

3. **Ending Questions** (to wrap up and final comments)
 - a. How would you like to see services in this area develop to meet your needs – if you were in charge what would you want to see happen?
 - b. Do you have any questions or comments to make about the services we’ve talked about that you’d like to pass on?

ALLOW 5-10 MINUTES

NB: I’d recommend around an hour not much more, you can see how the discussion flows in terms of timing, so that if you are getting a good contribution let it go a bit longer and if not move on. If you want to know something in more detail do probe and question in between but try and keep it flowing. Keep people on topic as much as possible and give eggs if people aren’t sure.

IDENTIFYING THE HEALTH, HOUSING AND SOCIAL CARE SUPPORT NEEDS OF BME OLDER PEOPLE OF AFRICAN (INCLUDING SOMALI) AND CARIBBEAN DESCENT – Project Proposal by UACS

1 Background: Health, Housing and Social Care Issues Affecting BME Older People

(Sources: 2001 Census, Ealing Supporting People Strategy, Ealing PCT Annual Public Health Report 2003-04, Ealing Health Profile 2006, Government of London, Ealing Health Inequalities Strategy 2005-2010, Ealing PCT Local Delivery Plan 2006-08)

1.1 Demographic Issues

The Black population within the LB Ealing rose 60% between 1991 and 2001 (compared to 40% increase in BME overall), and is the 2nd largest minority group in the Borough, making up over 20% of all minority ethnic residents.

16% of Ealing's Caribbean population is over 60, by far the highest among minority communities

- 95% are living at home
- 44% have no transport
- 36% live alone
- 26% report poor health
- 52% have a limiting long-term illness

Over 65s from BME communities are expected to increase to 28% by 2011 within the over 65s population, 8% will be from African/Caribbean and other black communities.

1.2 Housing Issues

75% of the older population are homeowners and only 5% of over 65s are in sheltered housing—therefore there is a greater than average need for outreach services, greater risk of isolation, and greater need for support for older people to remain independent.

1.3 Health and Social Care Issues

Ealing's Black and Caribbean population has significant issues with long-term illnesses, including premature ageing issues and early onset dementia. Therefore high care needs will not be confined to over 85s.

There are exceptionally high rates of diabetes among African and African-Caribbean people. In terms of the black community, strokes are much higher than average. 10% of Caribbean people reported they were in 'not good' health—third highest ethnic group and Caribbean people had 1.5-3 times as many GP consultations as the rest of the population

Black people over 50 reported higher levels of limiting long term illness than other ethnic groups. Black people were less likely to consult a GP about their mental health, 'and there is evidence to suggest inequities to accessing appropriate mental health services among these groups.'

2 Background to UACS

2.1 The Rationale for the Provision of Current Services

The United Anglo Caribbean Society (UACS) is a registered charity, which has been in existence for over 39 years. UACS was established by West Indians who saw the need to eliminate discrimination and promote equality of opportunity and good relations between the host community and people from the Caribbean and Africa.

People of African Caribbean decent come from very diverse ethnic backgrounds but uniquely share a common culture by virtue of the fact that they are from Africa / the Caribbean.

We acknowledge the diversity within the Caribbean community and we also recognise that, **ALL** people of minority ethnic backgrounds can experience common barriers in accessing health, housing, support and employment.

2.2 Our Services

2.2.1 Campaigning

UACS was the original campaigner for the development of a Supported Housing Scheme for elderly people in the London Borough of Ealing called Antilles House. The scheme has 52 one bed roomed flats and was originally specifically for people of African and Caribbean decent. Today, the scheme is open to older people from any community.

2.2.3 Current Services

- The Black Elderly Luncheon and Social Club is located on the South Acton Estate. The Club provides a range of social activities from Tuesday-Friday, 10am-4pm. The club has a thriving membership.
- UACS runs an Outreach Service for Older People. This project compliments the Black Elderly Luncheon and Social club and provides support to older people to help them gain access to basic and specialised services whilst living in their own homes.
- George Doyley House, established in 1993 is a Hostel for homeless young people of African and Caribbean decent aged 18-25 with low support needs.
- Our Housing Advice Service provides assistance to homeless people of any ethnic background. We received funding to deliver this service in five London Boroughs, Brent, Ealing, Harrow, Hillingdon and Hounslow.

Our projects serve over 550 individuals per year, and demand continues to grow.

3 Aims and Objectives of UACS

3.1 Mission Statement

To promote the health, security and wellbeing of people of African and Caribbean decent to enable them to fully participate in a civil society

3.2 General Objectives

- To develop a range of responsive services designed to meet the, health, housing and support needs of people from the African and Caribbean communities

- To collaborate, as appropriate, with other local and statutory agencies to deliver local and national health, housing and support agendas aimed at addressing the discrete needs of the minority ethnic communities
- To identify (and also assist in identifying) the gaps in the current provision of health, housing and support services to minority ethnic groups in general and people of African and Caribbean decent in particular

Specific Objectives

1 *Older People Services*

- To provide caring and supportive services to elderly people of African and Caribbean decent
- To provide a safe and supportive environment for elderly people of African Caribbean decent to engage in social activities and interact with people from their own cultures in order to: (1) address issues of isolation and; (2) promote their health and wellbeing
- To provide services to meet the needs of African and Caribbean elderly people who are housebound, isolated and in need of social interaction as well as health and support services
- To work with other health, housing and support agencies to ensure that the needs of the African and Caribbean elders are addressed as part of local health, housing and support strategies for older people services

2 *Services for Young People*

- To provide shelter for homeless young people of African and Caribbean decent
- To provide appropriate support for young single people to enable them to manage their tenancies and develop skills for independent living
- To facilitate access to services designed to assist young homeless people and overcome the emotional impact of homelessness so that they are better able to fulfil their potential and participate in a civil society
- To work with other local and statutory agencies to prevent homelessness among all young people especially those of African and Caribbean decent.
- To assist statutory agencies to fulfil local strategies designed to address homelessness issues among young people in general and those from Black and minority ethnic communities in particular