

Community Focus Group with: Somali Women's Group

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Background: Healthwatch Southwark

As part of the Health & Social Care Act 2012, Healthwatch Southwark (HWS) was established in April 2013, delivered through the contract won by Community Action Southwark (CAS). Supported by a National Healthwatch England, HWS is intended to advocate the local consumer voice and champion patient and public involvement to influence, shape and ultimately improve health and social care services in Southwark.

For Healthwatch to be representative of the local community's voice (and needs), we need to engage with a wider and more diverse part of the population, in particular the seldom heard, hard(er) to reach groups, or those not typically involved in consultations or statutory engagement structures. Thus, we will be holding an ongoing programme of Community Focus Groups. This is part of our bigger engagement strategy; to engage and involve both community and/user groups, and the wider population.

Programme aim:

- To develop a body of knowledge, insight and issues: across different groups, and/or specific to groups.
- Develop and building relationships to inform and feed into our priorities and activities
- Used to influence specific services, and longer term shaping to local services.

Focus Group aim:

To explore the key issues within these communities, specifically:

- 'Shine the light' on health and care behaviours,
- Gain insight into the challenges they face, specifically and in general

What we will do with it:

Develop ways to address them working in partnership with those bodies responsible for health and care services. They will also be used to inform our priorities, and where appropriate, we will directly engage with specific services.

Profile of the Somali Community

Based on the latest 2011 census data, there are 674 Somalis living in Southwark - this is 0.23% of the total population; however there is no separate 'Somali' box on the census form so the Somalian population may be underestimated due to many people ticking, for example, 'African' or 'Arab' rather than writing 'Somali'. There are 1,359 people (0.5%) whose *main* language is Somali, although this only includes people of speaking age and whose main language is Somali, and does not include languages a person *can* speak.

What we did

We met with the Somali women's group at the premises where they run their activities. We had been talking with the Bengali women's group also to see if a joint session could be run, but it was decided that separate sessions would work better for each group. Together, we discussed and planned how best to run the session, taking into account which day would work best, time of day, refreshments and language support needs.

The session was delivered at the Rockingham Community Centre. The group coordinator invited women from her networks to attend the session. Many of the women who could attend were young mums, so arrangements for a crèche worker were made to care for the children while the community focus group was in session. An interpreter and catering was also provided.

We started the session by explaining to the group what to expect and covered housekeeping notices. We introduced ourselves and invited the attendees to introduce themselves also and to share some of the services they currently use in the borough.

As with all Healthwatch Southwark community focus groups, we continued the session by going through our short survey which asks about the health services participants use or are aware of, what kind of health conditions people have currently and if they feel supported to manage them. We also ask if they access any social care services and if they have any general quality issues. Although we had an interpreter present, we conducted the session in English because most attendees spoke and understood a proficient level of English. The interpreter clarified any questions needing a bit more explanation.

Issues raised from the introductory survey were explored in group discussion. The key topics were:

1. Key challenges or barriers in accessing health & social care services
2. Needs specific to the community ('Cultural Needs')
3. Ways to offer 'good quality services'
4. Best way to get and obtain information

Overview of the women who attended:

- **There were 9 women present** and participating in the discussion. Some joined the session part way through with the majority of the group present throughout.
- **Most were able to communicate in English without the support of the interpreter** and were relatively informed of the various health services available in the area. Some had previously lived in Scandinavian countries such as Sweden.

- Majority were based in Southwark around Aylesbury, Villiers and Falmouth estates although a couple were based at New Cross , which borders the Lewisham borough.

Findings

1. Health Services

1.1. Use of primary care services

Not surprisingly, **primary care services were the common form of health services used** with all attendees having accessed GP services and pharmacies, with 6 of the 8 using dental services and 3 of 8 using opticians. Given the nature of the group, over half of the women used maternity services in the last 5 years, 3 of the 8 had used outpatient clinics and 2 of 8 had used community services¹ focused around paediatric care and acupuncture². One women identified as using alternative remedies, namely cupping, which we were informed was considered a ‘*typical Somalian*’ (and also ‘Islamic’) service. Another considered reading the Qur’an which she viewed as ‘*psychological therapy*’.

None of the women required an interpreter at their GP appointments. [As mentioned above, the interpreter was not required and the session took place in English.] **We asked if they knew all the services their GP practice offers.** Out of the 9 women present, 1 said yes, 2 said a bit and the remaining 6 did not.

1.2. Long term conditions

4 women identified themselves as living with long term conditions. A long term condition (LTC) is a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies (Department of Health). The identified LTCs included hearing impairments and wearing an aid, asthma, migraines and blackouts, chronic pelvic pain and bleeding/clotting disorder.

Of those with long term conditions, two felt they **were supported** and the same number felt they were **not supported** enough to manage their condition. For those that did not feel supported, we asked what they support they would like **to manage their long term condition.** Based on their experiences, themes and issues focused on: communication, information and understanding - between patients and staff but also between staff professionals and medication prescribing - how it could have an effect on their wider lifestyle and more specific concerns.

¹ We defined ‘Community Services’ as hospital care that can be provided in the community such as GPs, at home, centres and include services such as district nursing, foot health, rehabilitative services and more.

² Acupuncture is a treatment derived from ancient Chinese Medicine in which fine needles are inserted at certain sites of the body for therapeutic or preventative purposes.

<http://www.nhs.uk/conditions/Acupuncture/Pages/Introduction.aspx>

One example highlighted how she felt that the diagnosis of her clotting disorder could *“could have been better and done in a shorter time”* instead of the 6 years it took. During this period she was not given support and was left feeling isolated, and she suffered with pain - *“...not given the support and help for the treatment I need...have just been left out and isolated for this pain.”*

She also highlighted the **discrepancies in care treatment**, particularly supportive treatments offered whilst she was pregnant such as physiotherapy / hydrotherapy but not when she was not pregnant. Healthwatch recognises the clinical priorities for pregnant women who are deemed a higher risk, and the challenges in diagnosing certain conditions, however, this experience does highlight the **limited communication and understanding between staff and patient regarding care treatment.**

Another issue was around how **medication is prescribed** and this includes **understanding the circumstances of the individuals.** Circumstances can affect how successful the prescribed medication will be in terms of individuals taking the dose and any knock-on effects on their home life and wellbeing - *“Medication makes me dizzy and less alert - I don’t take it because I have small children.”* This was also raised in our Bengali Focus Group.

When questioned further around **pain management**, suggestions focused on psychological therapies (talking therapies) to help manage the pain component which can be a key aspect of their long term condition. This complements other experiences Healthwatch has heard collected from other sources - implying therapy is another way to manage the pain component common in many chronic conditions, *“Therapies to help with the pain should be offered because a lot of it is in the head.”*

Another issue was a **lack of communication between GPs and hospital services** around long term conditions, which further adds to stress alongside managing the condition. Some comments:

- *“My GP was not aware of my situation [because I was being seen at the hospital]; communication between the GP and hospital was terrible.”*
- *“...I have been going through load of stuff and have been very disappointed.”*

Another lady highlighted that she only received repeat prescriptions to address her migraines, but **did not receive any information around the causes or triggers of it.** She did not receive an investigation.

1.2. Experiences of GP services

This section focuses on GP experiences. Issues focused on positive and negative aspects on practical aspects such as getting an appointment, waiting to be seen whilst physically at the surgery, continuity of GP, and GP mannerisms.

Some **positive comments** focused on being able to easily call and see a GP:

- *“In my GP practice I get to see a GP easily - I can call in advance”*
- *“My GP is easy, I can call and I can go, it’s comfortable to talk and easy”*

Some **not so good comments** focused on getting appointments, waiting times, not enough time, continuity of GP and staff behaviours:

- *“Impossible to get appointment, been there 2/3 years. Walk in clinic where you sit and wait for 2-3 hours to be seen, often you sit and wait for the same amount of time for an ‘emergency appointment’” [long wait for an ‘emergency’]*
- *“I’m quite rushed, even though I make double appointments there isn’t enough time to talk, I don’t know if its rushed because they are late but I ask for double appointments so I can talk to the doctor.”*
- *“They will keep you there [waiting] even when the doctor isn’t there, until he comes.”*
- *“You see a different face every time you go in, it’s just been going downhill - it used to be one of the best surgeries. Most of the GPs there come across as being lazy or can’t be bothered - they want to get you out the door like a factory. She [female doctor] won’t give you the chance to speak - recently asked for the man [male doctor] even though I’d like a women but she isn’t nice. If she is the only one I can see, I won’t take the appointment.”*

Most of the negative experiences centred on one GP practice; however attendees were from the local area and this would skew focus on local practices. One person said they wanted someone who was able to *“listen to you”, “try to understand”* and to *“take complaints seriously.”* She referred to her previously feeding back through the complaints box but said - *“don’t know what happens to box...”*

Another highlighted that although she found it easier to see a GP [this was a different GP practice from the others] she still found she had to repeat herself and said *“they should know the background of patients...especially those with long term conditions.”*

1.3. Ideas to improve access for Somali women

In response to the above experiences, we asked how they could be addressed:

- *“Listen to you and understand”*
- *“Give us the time we need to talk”*
- *“Put out opportunities to complain more”* - Through Healthwatch, we have found that patients and the public interchangeably use the term

complaints and feedback. It is only professionals who tend to differentiate between the two because of the different processes involved.[see Section 7 of this report]

- *“Training”*
- *“A system that doesn’t require you to explain your whole health story each time you see a different professional”*

1.4. Experiences of hospital services (see also Section 2)

Other issues that arose focused on **staff behaviours** which included negative mannerisms or mannerisms that gave a ‘*rushed*’ or ‘*lazy*’ perception of staff. One experience related to a mother who had given birth and wanted help from a midwife to learn how to breastfeed. The midwife assumed that the ladies who accompanied the mother were mothers themselves and able to teach the patient how to breastfeed. This was upsetting to her, but also she wanted to be taught how to breastfeed correctly and she was not able to - *“First day she gave birth, [we asked] - please can the mother have help to breastfeed - when we asked the midwife they asked why we couldn’t help her ourselves - how could they assume we had children, it wasn’t right” ...no midwife/no help - I couldn’t breastfeed...my bed was needed”*

This experience inferred a **staff and bed capacity issue**. A similar experience, although a few years ago, also suggested bed capacity issue with a lady asked to move to another location following her caesarean - *“I had my daughter a couple of years ago - I had a caesarean and was told that the bed was needed that I needed to go to St Thomas”*

Another issue focused on the lack of and importance of communication between patient and professional during care treatment - *“[Relating a Caesarean] - I understand what’s said and they write records down and they could’ve spoken to me when writing...”*

2. Pathways

We asked the group about their patient journey (experience of navigating pathways) between different health professionals such as the GP and hospital or during discharge from hospital.

Across their experiences, **communication** in all its forms was a huge issue across all settings, particularly for ongoing care and treatment.

Patient notes being sent to GPs and Hospital following treatment: This affects how informed professionals are in order to diagnosis treatment, and if patients are able to obtain their medication because it depends upon GP’s getting the

specialists medication advice so that they can write the prescription - *“The GP cannot give medication...physio had to write to GP to get medication...”* It can also cause inconvenience to those having to stop a treatment and then return to treatment after a break.

Story

“I started physiotherapy when I was 8 weeks pregnant. I was discharged because they only deal with pregnant women. When I started again after having the baby, I had to start the process again and they didn’t have the information [from before]. It just says that I was referred but all the notes are not kept together. I was expecting that the physiotherapist would communicate with the GP but they didn’t. This was at Guys hospital and now I am paying £40 to get my notes - it shouldn’t be that way”

Professionals are **not communicating verbally and directly to patients**, ironically as they are writing down patient notes. Some even spoke about them over their heads. Some found this offensive. Some comments

- *“...the professionals talk over your head... ‘She needs this’ or ‘this is happening’ and I just want to say ‘hey! I’m right here!!’ I’m quite a curious person and I’ll read all the leaflets. I’m not a confrontational person but I was annoyed that they didn’t talk to me directly”*
- *“Don’t feel comfortable/confrontational to ask doctor but find it offensive”*

Different information provided by different professionals meant it was hard to know what information/advice to trust - *“Lack of communication and organisation, each professional will give you different information - cuts with lack of staff as well, it’s overcrowded everywhere.”*

Family members are not provided with information and in some cases, family members actively chasing information because the patient did not have the information themselves.

- *“They knew about her other conditions - I had to ask the people, they weren’t really informing me of what was going on. She was satisfied so I didn’t feel I needed to ask for anything more.”*
- *“..I had to ask but mum was happy.”*

This was **crucial for carers** of individuals with chronic conditions, who wanted information such as leaflets on pain and the condition, to understand and support their relative:

- *“It’s good for family/carers to know what this sort of process is... there should be some leaflets or something.”*
- *“Good for chronic conditions for carers - what pain information and what it is - leaflet”*

One experience relating to a daughter's observation, acting as an informal translator, that her mother did not get the information she needed at appointments and felt the professional's attitude could be patronising. However, she did not want to complain because her mother was satisfied. *"I used to interpret a lot for my mother; she wouldn't get the information she needed at appointments. They would say 'hello, how are you' and pat her hand - it was so patronising."*

Another issue highlighted the **communication within the hospital team and doctors** which resulted in a mother waiting 11 hours for a doctor only to be told he had left, but also the long time taken to diagnose. This followed after she was discharged - *"My child was crying, we noticed that she was crying from pain. I had to stay there at 9 in the evening [to take care of her] - I had waited 11 hours for a doctor and was told the doctor had gone home. It took 2 months for me to find out what the problem was. My daughter had green poo [and I can't believe it took that long to find out why]."*

3. Information

We asked the group **where they would like to get information from**; the group responded with the GP, verbally and with leaflets written in Somali.

We asked **where they went if they needed advice or information**; the women told us different ways depending on the nature of the query. **Specific services** they use such as foot clinics or GPs and receptionists at GP practices provide them with relevant information - *"information about my feet and legs, its good"* [reference to foot clinics].

However, some said that **GPs and GP receptions did not always have information** they needed and in some cases, they still did not know the answer. Interestingly, some felt that in relation to the **idea and role of GPs**, GPs should be able to diagnose/clarify the cause or pinpoint the condition, without giving options of what it could be.

- *"Receptionist and GPs didn't know where to get children's blood test as children need different blood test. I still don't know how and where to get one for my son."*
- *"I feel that my hand/head... I should be able to say one thing and find out why rather than say it could be this, this and this..."* - [Relating to the idea/role of GP]

They also referred to more **communal and community interactions** such as bus stops, friends, family, this community group and mothers outside of school dates as another way to obtain information - *"Ask friends, relatives, each other, mothers outside the school gate..."*

Another source was **Google**. They referred to the need to be educated before the appointment, to avoid patients being ‘passed around’ and getting the most/more detailed information out of the appointment:

- *“Patient needs to be informed before appointment”* [Google].
- *“Need to be educated otherwise you will get passed around...you need to know what you could need. For example MV passed around...”*
- *“Educate myself in order to give me deeper advice”*

NHS Direct (now known as **NHS 111**) was also referred to, alongside **printed information such as leaflets**. When asked where the women would go if their GP practice was closed, there was a **general awareness of alternative services outside of GP working hours**. Out of the 9 woman present:

- 2 used SELDOC (South-East London doctor’s cooperative/GP-out-of-hours service),
- 4 used the Lister Walk-In-Clinic (now closed as of November 2014),
- 3 used the internet,
- 2 used NHS Direct (now the new 111 Service).

4. Social care

Out of the 9 woman present, **none of the women had used social care services**. This included accessing personal budgets, or as a carer for a family member or friend. We also gave a brief explanation of social care and the difference between a Paid Carer (i.e. working for an organisation or local authority to provide home care) or a Carer who provides a substantial caring role.

[Social Care support](#) refers to services to help people who are in need of practical support due to illness, disability, old age or income. It can include personal care services (i.e. helping to clean, shower, eat) to moving around or manage your life.

5. Cultural needs

We asked the women if there were any different cultural and/or specific sensitive needs that would help staff and professionals, and enable the Somali community to access health & social care more. The women told us about assumptions made, being treated with dignity around their cultural needs, and having a conversation if interpreter is needed.

Assumptions were made around an individual’s English skills and education level and that they would not be able to understand. This caused distress to the individual and family member, and occurred when certain attire was worn such as a hijab or ‘big scarf’:

- *“People see a woman, big scarf and think she wouldn’t understand. I have been quiet in a meeting and then when I have spoken, I’ve been told that*

I've got good English - then they look scared and then people look like they are being careful about what they are saying"

- *"People think that you are uneducated" - [relating to women in hijabs]*

One example referred to a mother's experience where her child of mixed heritage was subject to questions on his 'physical size and assumptions were made on his linguistic/cognitive development, not about why they were here at an initial GP assessment. She felt very upset and even considered it to be racist, based on an assumed judgement - *"...GP asking questions about this (initial GP assessment) not related to why we were here to. For example 'he looks quite big', does he speak? Relating to his development because he's tall... I said 'do you speak Somali'? Felt really upset and 'racist'. Just because he doesn't speak English doesn't mean his dumb..."*

The individuals felt that regardless of what service is being accessed, they should all be treated with dignity (including avoiding patronising behaviour), taken seriously and offered an alternative space to pray. One experience related to an older family member where language was a factor and meant the daughter translated during the sessions. She felt that the GP's behaviour was 'patronising' to her mother, which could be because of language or age or both.

- *"I should be able go somewhere and be taken seriously"*
- *"Treat with dignity - they are more aware now"*
- *"Prayer room or an alternative space to pray offered"*
- *"GP can be patronising, smiley, mother. Treated differently"*

It was felt to be important to have a conversation with the individual about whether interpretation is needed at appointments and not assuming that family members can be there or that even an interpreter is needed when it is not - *"Interpretation if needed - not family members to be there at appointments", "sometimes an interpreter is there even if you don't want one - ask what we need."*

There were also **specific things** identified that could affect people's interactions with health professionals - such as preference for female doctors and that birthdays are not hugely celebrated. This suggests that this may require a little more understanding or other alternatives, for example, if individuals incorrectly give their date of birth as a means to confirm identity or appointments. However, again this requires conversation with the individual and family.

- *"Somali women would prefer female physicians with good experience"*
- *"Birthdays, we don't celebrate birthdays. We will know the year but not the specific date because it's not something we celebrate"*

Similarly, a few raised positive and negative experiences around how health professionals examined, as mentioned earlier. They suggested and preferred to be

asked how they want to be examined, or if it was okay if they could do this, or letting them know that they were going to do this. The good experiences reflected professionals aware of a patient's religion and taking steps to consider this in their care, and also professionals treating patients with respect by asking questions and letting them get involved in their care.

6. Mental health

The subject of mental health was raised by the group. They gave insight on how the Somali community viewed mental health and gave recommendations to increase access and information. The group generally were well informed and understood the nature of the mental health.

Insight focused on the 'taboo' nature of mental health and that people assumed it was associated with being 'crazy'. The group highlighted that the *"awareness isn't there"* and that it is not just about being crazy but there are different levels which include anxiety:

- *"Mental health is a taboo subject in our community - the awareness isn't there, the first thing that comes to mind is that the person is crazy"*
- *"Taboo is not just being crazy, it's anxiety. People's first thought about mental health - you are crazy, but there are levels of mental health..."*

Another interesting view was around **postnatal depression**. They highlighted that there is a cultural view that Somali women must be strong and they suppress postnatal depression - *"Many Somali women... there is culture of being strong and suppressing depression."*

They highlighted that *"feelings [we] don't focus on as much..."* Both medication and counselling (or talking therapies) were viewed negatively and if you suffered from mental health issues, religious judgement about your faith could be made on you. Again the group were very aware of the clinical nature of mental health, and even sought to question this viewpoint around religion - *"Taking medication and accessing counselling is looked down on, it says that you do not have strong enough faith."*

They also mentioned that if you were accessing either, you would keep quiet - *"Counselling - accessing and taking meds and keeping quiet"*. One lady was informed around her **chronic pain** to understand she wanted a therapist to *"de-programme [her] pain"*. However, she did not want to be labelled as 'depressed' and this was in reference to a form she had to fill in around symptoms - *"You have to fill in a form; you can tick all on the form but wouldn't call myself depressed. i.e. sleep, isolated etc. You suppress it as much..."*

6.1. Suggestions that were made

- Making sure referrals and the process to be assessed are easier and quicker, citing long waits and a lot of energy and stages to go through it.
- Having someone based at the GP to provide counselling or psychological support.
- Providing more information on mental health to the community particularly the older generation, those who don't read or have recently arrived from Somali.
- Word of mouth or outreach workers providing information, both are ways that worked around providing information. More reading materials were not always understood or there wasn't much available:
 - *“There used to be Somali outreach workers who gave information to the community; that worked well for us.”*
 - *“...more information about mental health for the Somalian community. The older generation don't really read, so it's like they're straight from Somalia...”*
 - *“Information not understood and think and read, not much to read”*
 - *“Usually word of mouth - session like this...”*

7. Giving feedback

Note: In most of our sessions, people tended to refer to complaints and feedback interchangeably. We have tried to differentiate between complaints and feedback. We refer to complaints as a singular issue that follows a technical structure to be resolved. We refer to feedback as comments intended to enable the provider/service to further improve services.

When asked how they felt about giving feedback on the services they receive, the women told us that **they do not always know where to complain** and are **doubtful if it will be taken seriously**. As mentioned above under 'Experience of GP services', one highlighted that she did not know what happens to her complaints/feedback when she inserts it into the complaints box.

Similarly to other feedback we have received [see Bengali Focus Group], people worry that **complaining would affect the service they currently receive**.

- *“You don't know how this would affect the service you get.”*
- *“... don't know where to, if [will be] taken seriously...”*

8. Summary

GP and maternity services were the main services used. However, the women also highlighted the use of alternative services such as cupping which some viewed as 'traditional Somalian' (and also 'Islamic') care, and 'Qur'an' which some viewed as psychological therapy. Not surprising, many were not aware of all services available at GP practices.

Those with long term conditions had mixed feelings about being supported in managing their condition. The issues highlighted focused on:

- **Different care treatment received for the same diagnosis.** Patients did not understand the difference in care treatment. This highlighted a lack of communication and understanding from both the patients and doctor's about the patient's care.
- **How medicines were prescribed and its effects on the individual's circumstances** did not always take into account a patient's wider circumstances such as having young children, which could affect whether the individual would follow the medication or not.
- **The lack of communication relating to patient notes and updates between GPs and Hospitals,** resulting in patients repeating their stories and being treated/diagnosed without professionals being fully informed of the patient's status.
- That **psychological therapy (talking therapies)** should be offered as a way to manage pain for those with long term conditions.

GP experiences highlighted similar issues that could become either a negative or positive experience. They focused on practical aspects in getting through to doctor and seeing them, waiting time in the rooms, GP mannerisms and having the same GP. People want GPs to listen, understand and take complaints seriously. Those with long term conditions want accessible patient notes, to avoid repeating their life story again.

Hospital experiences highlighted negative staff behaviours such as patients perceiving them to be lazy or feeling rushed during care/consultation, and assumptions about a patient's capability e.g. around breastfeeding, as well as issues in communicating care to the patient.

Communication was a huge issue around patient pathways across providers and primary and secondary care (GPs and hospitals). There was little communication between professionals, between patients and professionals, and with family members, with some actively chasing information. Different information was also provided by different professionals.

The group **obtained their information** from specific health services they used, GPs, receptions, community interactions such as events, bus stops, school gates, Google and national information sources such as NHS 111. Those who raised Google as a source emphasised the need for **patients to be informed before** they attend their consultation to get the most out of it. There also seemed to be a perception around the **role and idea of a GP**, where people felt more concrete diagnosis/options should be given rather than lists of possible diagnoses.

In general, the group's **cultural needs** focused a lot on assumptions, intended or not, about the individual's understanding, education and language skills. These had a negative effect on the group, as they valued not being treated differently but with dignity and respect. Professionals should ask whether an interpreter is required and not assume either way.

Mental health is a 'taboo' subject in the community and there is a lack of awareness about what mental health means. Postnatal depression could be an issue because of the cultural perception that Somalian woman should be strong to manage birth and suppress problems. Feelings were not really talked about and so talking therapies and medications were viewed negatively and those that were under treatment would not admit it. If one was suffering from an illness it could be judged that their faith was not strong enough. Talking therapies were seen to be crucial for patients' mental health if they have a LTC with a chronic pain component.

The woman did not always know where to complain and were doubtful it would be taken seriously if they did. They also worried that if they were to complain, it would affect their current care.

Next steps and considerations

The issues arising from this report will feed into our work plan and activities. These include through our Representatives at strategy and programme boards, particularly the Primary & Community-based Care Strategy and its development, 111 development and equality and human rights emphasis. References will also be made in our consultation responses and also as part of our feedback to CQC inspections of GP Practices and Hospitals, public forum planning and any other appropriate platforms that arise.

More information and communication with Practice patients needs to take place to ensure they are informed of upcoming changes and able to access services if required or relevant. Changes include the extended access clinic, IAPT and other community services available. Many patients highlight that awareness of services available to them will increase their use, and will also help address the inequality that CCG seeks to readdress through its Primary Care Strategy and the Neighbourhood Locality Model.

More focus on support for younger individuals/mothers/families with complex long term conditions should be available, because of their key role in the family unit. This includes specific considerations around *managing their pain symptoms* through help such as IAPT and the *effect of medication* on their wider lifestyle.

Medication and its effects need to be discussed with the patient but should also include discussions to address the patient's concerns around their family life and cultural perception. Further work could be explored to see how prevalent this issue is for those from a different cultural background and /or family.

GP experiences can be greatly enhanced if all **professional interactions are aware of how they interacted with patients and paid attention to the softer aspects of care**, around being listened to, empathetic, and to be receptive to feedback or complaints. Practical aspects such as prioritising those with LTC with a consistent GP, accurately updating patient records, and a review of the best way to contact a GP practice, should be looked at.

Communication must include patients and keep them involved in discussions about their care and treatment. This will ensure both parties understand the treatment options and will increase success in management. Where patients use services outside of their GP practice, patients should be informed at the consultation and along the way, verbally and through letters. Hospital teams also need to make sure patient records are updated to avoid the patient repeating their story to other professionals.

Information sources should be varied, and should include well-informed receptionists to give out information or signpost people to information sources. Where possible, depending on the location of the services, leaflets in another language could be an option if there is an appropriate demand for it. Wider understanding of the role of GPs and how they work/diagnosis could help meet patients' expectations.

Assumptions should not be made relating to an individual's education, literacy or language skills, however well-intentioned. Checking with the individual is usually valued.

Mental health remains a taboo in parts of the Somalian community. Being aware of this and also encouraging conversation on mental health-related care will increase the chances of individuals getting the care they need.

Feedback needs to be encouraged and ways to make it inviting should be explored with PPGs. Making clear the distinction between Complaint and Feedback could help encourage feedback; however, further conversation and work needs to take place to ensure that patients who do feedback or complain will not see a negative effect on their care.

This report is available at <http://healthwatchsouthwark.co.uk/reports>
For more information, email info@healthwatchsouthwark.co.uk or call
020 7358 7005.