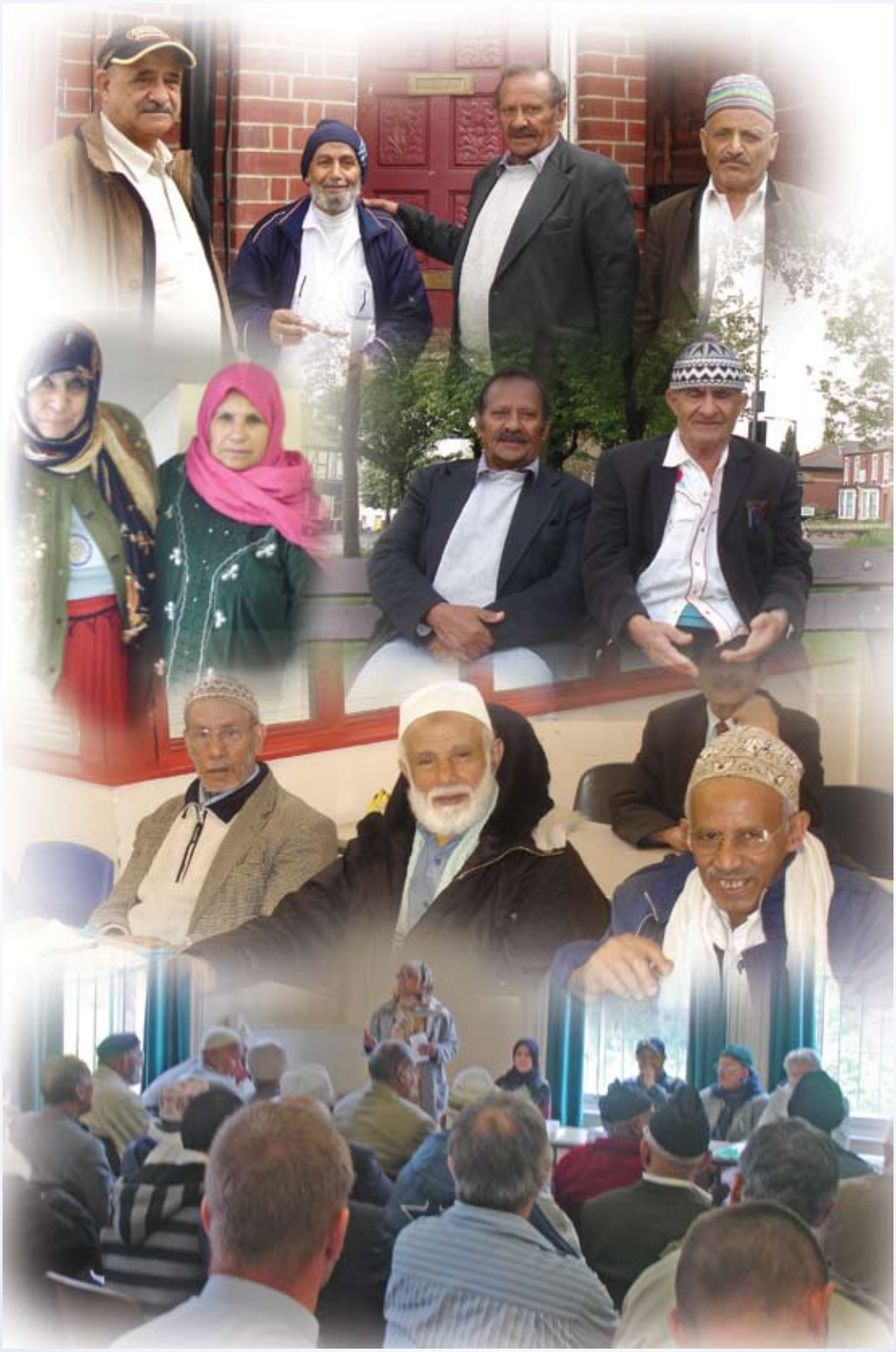
The Right To Be Heard
REMOVING INEQUALITIES

Consultation Event With Black and Ethnic Minority Elders



"Serving the needs of the community"

pca
multi-cultural advice centre

SHEFFIELD
2007

Contents

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We would like to thank our funders who supported the event:

- Burngreave Area Panel: Sheffield City Council
- Sheffield Primary Care Trust

Introduction

On the 24th of April 2007, 119 older people[1] attended an older people's consultation day organised by the Yemeni Community Association and the Pakistani Community Association. The purpose behind the event was to explore the needs of older people from black ethnic minority communities, giving them the platform to voice the issues that concern them and to allow them to make recommendations for future action.

The event was organised because of the increasing evidence (see page 7 - analysis of need) which shows that older people from minority ethnic backgrounds are more likely to face a greater level of poverty and are less likely to have specialised needs catered for by mainstream services.

The findings from this consultation event have shown results consistent with previous studies which show that elders from Black and Minority Ethnic (BME) communities do not receive the same services as their white counterparts. Lack of service uptake did not indicate lack of need but instead highlights a range of barriers which prevent accessibility. The barriers to participation need to be addressed collectively.

The common themes for barriers for BME participation include:

- A distrust of institutions
- Language and cultural barriers
- Lack of awareness of services
- Lack of local services

Recommendations have been made in **section three** of this report which presents the findings of the consultation. To value the contributions of the older people who have participated in this consultation we call for the appropriate bodies in the local authority to take note of the recommendations and agree a constructive way forward.

[1] See appendix 2 (pg 24) for a list of attendees.

SECTION ONE: THE CONTEXT

1.1 National context - An ageing nation

1.1.1 The direction for the provision of social care for older people is being shaped by the Government's vision set out in the White paper 'Our health, our care, our say[2]. This will sit alongside the NHS improvement Plan; the Public Health White Paper: Choosing Health[3] and the report from the Social Exclusion Unit (SEU), A Sure Start to Later Life: Ending Inequalities for older people. The latter aims to repeat the successful model of the Sure Start programme for pre-school children by providing "a single, accessible gateway to wide ranging services in the community, where potential problems are identified quickly and prevented from becoming worse[4]."

1.1.2 The SEU states that this approach will ensure services are for everyone, are flexible and proactive and promote well-being and independence. The need for strategies to safeguard independence in later life was also was regarded as critical to quality of life in an earlier government report.[5]

1.1.3 The ethos of all these papers is to provide older people with more choice and real control over their lives and the way services are arranged and provided for them. They are expected to set out the requirement for a continued increase in preventative and rehabilitative services to optimise and maintain older people's health and well-being.

1.2 The city-wide context - An ageing city

1.2.1 Sheffield City Council has been successful in securing £3.8 million in funding over 2 years from Partnership for Older People projects, which from April 2006, will support the approach to the council working with partners to develop integrated preventative services to meet the needs of disadvantaged older people.

1.2.2 This funding will allow the council to continue to work towards its vision of ensuring that:

"Older people enjoy an improved quality of life- health, and well being, are independent, participate actively in the community and enjoy the benefits of safe and stronger communities with equal access to integrated co-ordinated services.[6]"

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[2] Dept of Health (2006) Our health, our care, our say: a new direction for community services
[3] www.dh.gov.uk
[4] Social Exclusion Unit (2006) A Sure Start to later Life: Ending Inequalities for Older People: ODPM
[5] Social Exclusion Unit, (2005) Multiple Exclusion and Quality of Later Life amongst Excluded Older People in Disadvantaged Neighbourhoods.
[6] Sheffield City Council (2006) Neighbourhoods and Community Care Directorate. Older Peoples Service plan 2006 – 2007: p8

1.2.3 The Headline results in Sheffield City council's topic reports highlights[7] that Sheffield has an ethnically diverse population, which looks set to grow in the future, as proportions of black and ethnic minority groups are higher in younger age groups.

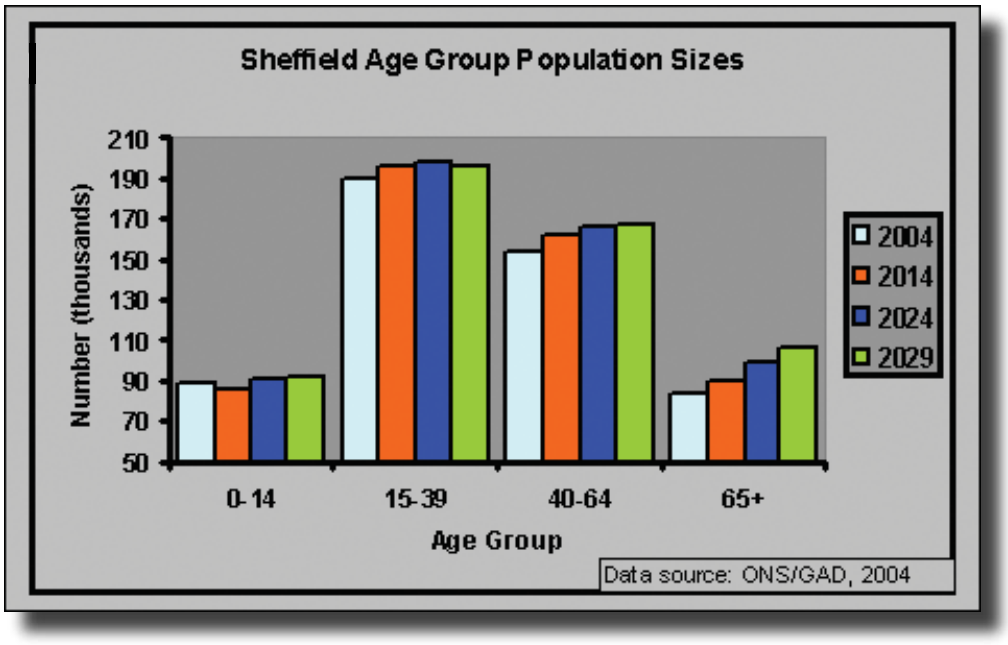
1.2.4 In 2001 the White British population was estimated at 457,700 people - giving a 2001 BME population of 55,400. More recent work (see figure 1 below) carried out by Sheffield City Council, suggests that the BME population in 2005 was around 69,300 people – making up 13.5% of the City's population[8]. The changing ethnic profile has resulted in Sheffield's population having a more diverse religious profile.

BME / White British Population Estimates in Sheffield

Year	BME Numbers	White British Numbers	Total Population
1991	36,500	483,600	520,100
2001	55,400	457,700	513,100
2003	61,500	451,000	512,500
2004	67,093	449,007	516,100
2005	69,300	451,400	520,700

1.2.5 2.6% of Sheffield's 60+ population classified themselves as being from a non-white background.

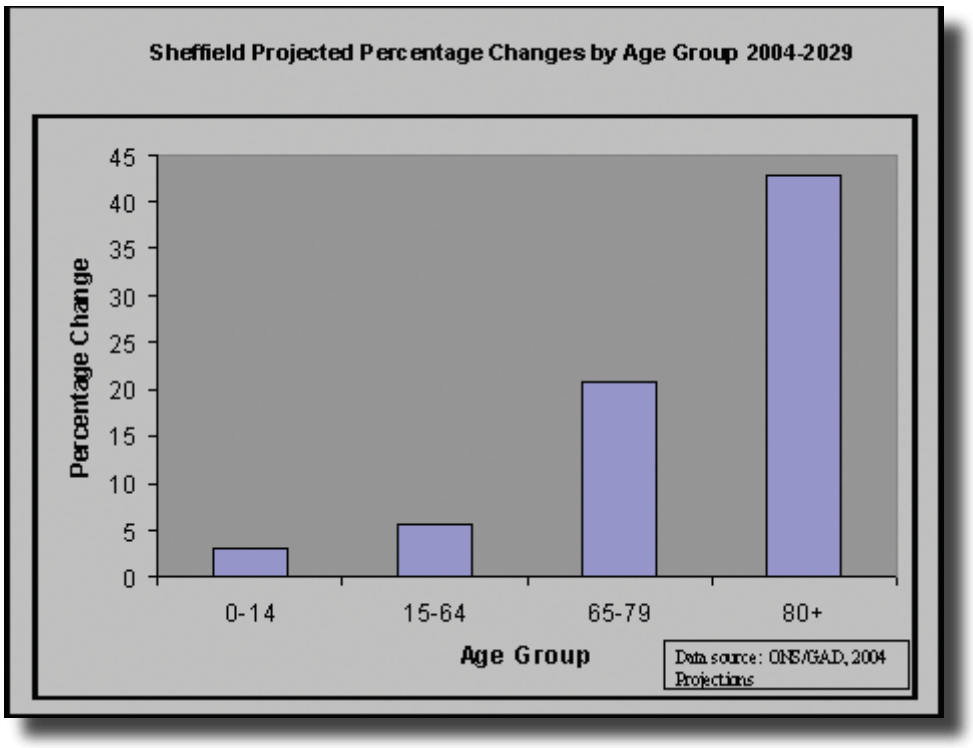
1.2.6 In general however, growth is expected, in particular, in the 65+ age group and some geographic concentrations of specific age groups currently exist and are expected to continue. Figure 2 (below) shows the 40-64 and 65+ age groups increasing in size, in particular. The projected increases in the older population can be expected to have considerable implications for service provision and policy for partners across the city.



[7] Corporate Policy Unit (2001a) Sheffield City council's census topic reports on Older People
[8] Sheffield City Council Corporate Policy Unit (2007)

1.2.7 Figure 3 illustrates the percentage changes in some key age groups – showing them all increasing up to 2029. It shows a notable increase of 43 percent for the 80+ age group.

Figure 3



SECTION TWO: Analysis of Need

Older people from Black and Minority Ethnic communities

Barriers to service

2.3 Older people from ethnic minority communities are not achieving equal access to social, health services. BME populations are the highest users of primary care services, yet they are less likely to gain access to appropriate health services and treatment and they report the worst health outcomes[9] . Ethnic groups with the oldest age profiles are likely to have the highest proportion of people with limiting long-term illnesses[10]. The ethnic groups with the highest levels of limiting long-term illness are the 'other mixed', Pakistani and Bangladeshi groups, which have around 30% increased chance of having a limiting long term illness compared to the Sheffield city average.[11]

2.3 The Sheffield BME Older People's Joint Service initiative conducted in 2005[12] found that if services are to be used, then the groups that they are aimed at need to know they exist and how to access them. The study found that there was a general lack of awareness amongst BME older people of the services available to them and that the numbers accessing provisions was not proportionate to the cities BME population which represents a major gap in service provision.

2.3 Access to mainstream services for black and minority ethnic older people remains problematic on a national scale[13]. Yet the lack of awareness of appropriate services is only one aspect of the multifaceted problems encountered by BME elders. Additional barriers include language, negative issues of service providers, poor mental and physical health, including professional assumptions that their family will provide care and a colour blind approach to service provisions and assessments[14]. Because of these barriers and a lack of effective consultation this has meant there are few services which are designed to meet the specific tailored needs of older people from minority ethnic groups.

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[9] ONS (1996) Social Focus on Ethnic Minorities. The Stationery Office. See also Barnes, M, Blom, A. Cox, K. Lessof, C. of the National Centre for Social Research, and, Walker, A. University of Sheffield (2006) The Social Exclusion of older people: Evidence from the First wave of the English Longitudinal Study of Aging (ELSA) ODPM.

[10] Office for national statistics (ONS) (2001) The 2001 Census on Population, CM4253, London: HMSO.

[11] Corporate Policy Unit (2001b) Sheffield City council's census topic reports on Ethnic Origin

[12] Analysis and Evaluation of current strategies: Policy Evaluation Group (2005) accessed at http://www.cat.csip.org.uk/_library/docs/Housing/BME/Bme_jointservice_sheffield.pdf

[13] National Black Carers Network in association with the Afiya Trust (2002) We care too: A good practice guide for people working with black carers , NBCN. See also Social Exclusion Unit (2006) A Sure Start to later Life: Ending Inequalities for Older People: ODPM and Age Concern (2000) Consultation Event with Black and Minority Ethnic Elders: Yorkshire

[14] Smaje C. Health. (1995) 'Race' and Ethnicity: Making sense of the evidence. London, King's Fund Institute. See also Bhopal RS, Donaldson LJ. (1998) 'Health education for ethnic minorities: current provision and future directions'. Health Education Journal, (47):137-140

2.4 Minority ethnic segregation and deprivation of older people has been attributed to a range of factors, long term poverty, systematic institutional discrimination, racist harassment and the pull of the ethnic cluster, for social and cultural reasons.[15] However such groups don't usually choose to segregate themselves these days. They feel that segregation is forced on them.

2.5 There is evidence that BME elders experience more discrimination in terms of both age and race than any other groups within the population in health, community and social care services, income and housing yet very little has been done to increase equality amongst minority groups.[16]

2.6 Older people from minority ethnic communities are not all the same as there are language and cultural differences between groups based on country of origin and religion. Yet all ethnic groups face similar barriers relating to equality in the take-up of appropriate services which includes overt and inadvertent racism at individual and institutional levels, cultural stereotyping and language differences.[17]

2.7 The Macpherson report revealed that the Metropolitan Police processes led to institutional racism which it defined as:

'The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.'[18]

2.8 Under the Race Relations Act 1976, as amended by the Race Relations (amendment) Act 2000, public authorities are placed under a legal general duty to eliminate unlawful discrimination. Sheffield City Council operates under the Framework of Fair Access to Care Services[19]. This framework fundamentally means that no-one has difficulty gaining access to whatever services are needed, regardless of age and race, the two defining characteristics of older people. However to promote accessibility the Joint Service Review found that public services need to be promoted to the potential users and the users need to be comfortable with what is on offer.

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[15] Harrison, M. and D. Phillips (2003) 'Housing and Black and Minority Ethnic Communities: Review of the Evidence Base.' London: Office of the Deputy Prime Minister.

[16] ODPM (2006) Review of the Evidence Base on Faith Communities. Mercia Group: ODPM. See also footnote 12, Ahmad, W. I. U. and Walker, R. (1997) 'Asian older people: housing, health and access to services'. Ageing and Society vol. 17, no. 141-65.

[17] Becher, H. and Husain, F. (2003) South Asian Hindu and Muslims in Britain: developments in family support. London: NFPI. See also Chevannes, M. (1996) Equality of opportunity for black and minority ethnic older people British Journal of Community Nursing, Vol. 1, Iss. 8 pp 472 - 476

[18] Accessed at http://www.archive.official-documents.co.uk/document/cm42/4262/sli-00.htm

[19] This is a central government requirement which underpins the council's approach to carrying out its work.

2.9 As a result the need for culturally and religiously sensitive services is strong. Additionally the predicted steep growth in the numbers of African Caribbean and Asian older people is only likely to increase the demand for community care.[20]

2.10 Research conducted in Scotland[21] found that the staff in the social work department had little detailed knowledge of the service needs of ethnic minority elderly people, and recognised this as a difficulty. They also felt that the departments attempt to publicise its services had been unsuccessful in increasing service uptake.

Muslim older people

2.11 Socio-economic indicators from the census reveal a consistent picture of the vulnerable positions of the aggregated Muslim population compared to other minority groups.

2.12 The focus on religion has been driven by both major international events which have highlighted the political demands associated with religious movements and by an increasing recognition by academics, policy makers and service providers of the importance of religion in defining identity.[22]

2.13 Although Muslims are not a homogenous group, the Somali, Yemeni, Pakistani and Bengali groups do fall mainly into the Muslim category.

2.14 In Sheffield the Muslim population is 23,819[23], 4.6% of the population which is above the national average of 3.1%

2.15 Muslims are more likely to be disadvantaged. They display low rates of labour market participation, the highest male unemployment rate, larger families, and highest incidence of overcrowding and are most likely to live in deprived localities.[24]

2.16 The 2001 census highlighted that Muslim groups have the highest rates of reported ill health in 2001 and had the highest rates of disability or long term illness which restricts daily activities.[25]

[20] Atkin, K. and Rollings, J. (1996). 'Looking after their own? Family care-giving among Asian and Afro-Caribbean communities', in Ahmad, W.I.U. and Atkin, K. (eds), 'Race'and Community Care, Buckingham: Open University Press, pp. 73-86
[21] Pathways to Welfare for Pakistani Elderly People in Glasgow Social Work Research Findings No. 8 (1996) The Scottish Office Central Research Unit
[22] see footnote 16
[23] see footnote 9
[24] see footnote 16
[25] see footnote 9

SECTION THREE: Findings

3. Homecare

The workshops found that both users and non-users experienced unmet needs. Needs were not met because of a lack of suitable services, lack of knowledge about services or individual choice not to use services.

Key issues included concerns around:

- Awareness and informational needs;
- Interpreting and communication;
- Meeting the religious and cultural needs of service users;
- The recruitment of a representative workforce;
- The quality of Home Care provision;
- Financial concerns expressed by service users

The following comments have been grouped into the above named categories.

3.1 Awareness and informational needs;

'I do not know what's on offer.'

'I do not go out enough to get information. The information should come to me.'

'I do not know what I am entitled to. Who is going to tell me. If I need something I'll go and ask. But I won't ask for something if I don't know what they do.'

'I didn't know I could get this service. If I did know I know I would need it.'

In general the older people had a profound lack of knowledge about the home care services available to the community at large. This consequently led to a lack of reported accessing of the service. Local knowledge of services provided to older people is essential if we are to develop a link with those who are most isolated.

Recommendations:

Public bodies need to improve their connections in the community to communicate their services to isolated groups. This can be done by:

1. Developing effective partnerships with established BME grass-root voluntary sector organisations that are an effective arm to reaching those most isolated in the community and communicating the services that are available.
2. Working partnerships can also increase take up and accessibility by developing a referral process between services.

3.2 Interpreting and communication

'I cannot read and write in my own language how can I understand anything.'

'I don't understand anything that comes, so I take it to my community centre so they can read it for me.'

This illiteracy in the mother tongue language highlights the need for verbal communication to take place to highlight the service provisions that are available. Language and communication play a significant factor as to whether services are 'known about' generally. Age Concern's Policy Paper on "Black and Minority Ethnic Elders' Issues" point to the fact that one of the main reasons for lack of awareness about services is the language barrier.

Not only does language need to be in an accessible format for people from all minority ethnic groups but mainstream services need to think about ways of tapping into these networks and more imaginative ways of disseminating information amongst communities.

Recommendations:

Promoting accessibility is not just about translating services but about making services known to the targeted user group regardless of race or language spoken. It is about ensuring that information about the availability of the service and the methods of accessing it are tailored to different groups and it is not always about changing the service itself. More needs to be done to support older people who will not access literature in the same way. This can be done by:

1. Developing alternative methods of communicating services which takes into account older people who are illiterate. For example this can include developing several workshops annually in partnership with BME voluntary sector organisations whereby older people are told verbally of what is available to them and possible new services.

3.3 Meeting the religious and cultural needs of service users;

- *'The service provision needs to take into account cultural preferences.'*
- *'I want someone who will make my food the way I like it. I want them to understand that I pray and I may need help in doing this. I don't want someone to come and question what I do like they are learning from me. I want them to already know.'*
- *'I want someone to help me cook my food that I always eat, the way I like it.'*
- *'I pray and I sometimes need help to do this, who will understand this.'*
- *'It has to be a female worker and she needs to understand what I do in my religion.'*

There were many more comments made on the need for cultural and religious understanding. The consensus was that this is what made the service more appropriate. Whilst there are common experiences across different communities, there is no universal experience common to them all.

Recommendations:

Meeting the cultural and religious needs of service users is essential if equality of opportunity is to be properly maintained. This can further be developed by:

1 Ensuring there is a representative workforce.
2 Ensuring service users are paired with staff who speak the same language as the service user and understands their cultural and religious needs.
3 Make use of the voluntary sector organisations that have specialist knowledge of various minority community groups to provide training to front line delivery staff.

3.4 The quality of Home Care provision;

'I never received the support I asked for.'

'I had one worker who was good but when she was sick they sent another one who didn't speak my language. I couldn't talk to her properly and I felt let down.
I didn't complain to the managers because I don't want to complain all the time. But I just feel like they should have known this without me telling them.'

'I asked for shopping and housework support. But the worker said I don't do this or that...I didn't want to complain because I don't want to get anybody in trouble. So I just stopped it and said I don't need the support when really I do. I'm old I don't need any trouble. If they are bringing in these workers they should explain to them what needs to be done.'

'Sometimes they say we are not supposed to do this or that. Or they spend a long time on one thing.'

'Staff do not care for what they do…so I feel like I cannot really ask them for help.'

'I'm not happy with the length of time things have taken me to be assessed.'

'Home care is not as it used to be.'

'I called my community centre to refer me because I needed help. They sent somebody to see me but then said I was on a waiting list!'

The comments made suggested that a provision of this nature needs to be one based on trust and understanding. Many said they felt ignored and unsupported and have stopped using the service because of this.

Recommendations:

1. Service users needs and opinions need to be taken into account when delivering a specialised home support service.
2. Regular monitoring on a continuing basis to find out which groups of people are using which services, which services are not being used and what the level of satisfaction is with the services that are being used - It is crucial to discover why there is an under usage of services.

3.5 Financial concerns expressed by service users

'I was getting support and then they tell me I have been charged because I get disability living allowance. But the charge is quite high, it is not reasonable. I am old and still have to pay bills for everything.'

'They charge too much even though I am on only on disability living allowance.'

'They provide very little service for the money they charge.'

The main reason I don't access social services is because it is costly for example if we need home help, we have to pay this from our DLA benefit.

Recommendations:

1. Service users need to be made fully aware of the costs of home support.
2. Appropriate free community activities should be delivered which promotes independence out of the home.

3.6 Carers

'I don't know of homecare but I need help with shopping and housework because my health is getting worse' The only help I get is from my son and he can't offer it all the time because he has responsibility and family to look after.'

'I am a carer for my elderly disabled father, and so have experience of the lack of help that is available. Being a carer is a twenty four hour job. I cannot do this without taking annual leave, my father needs support and is not getting it.'

The commonly held view that extended family will look after their "elders" may be a myth and certainly masks the level of true need.

4. Day care service and respite activities

This area was difficult to breakdown as there was no day-care service actually in place for them to comment on. However, the general feedback from the event was that older people wanted a day care service which reflected and catered for their religious and cultural requirements. Key issues included concerns around:

- No service being available
- Type of service required
- Preventative support

The comments have been grouped into the above named categories.

4.1 No service available

Many were disconcerted that despite the many years they contributed to support the economy working in dismal and underpaid conditions, they were now undervalued and ignored. Countless frustrations amongst the older people were voiced at the lack of services available to them in their localities and they do not hold too much optimism for any change.

'I worked in the steel industries for a long time.. now when we ask for things like day outings we cannot get anything. We have been used and are now ignored..It makes me angry... we always ask for these things and nobody listens.. its like we are not important.. I am old but it was people like me who helped to make this country rich.. we worked for practically nothing doing jobs which nobody would do and this has not changed because we still get nothing!

'When will they listen to us..its like we don't exist.. there has never been anything for us...'

'There is no where for us to sit, relax and spend time in the community. So we are left to stay at home all day and we can get depressed from this.'

'I don't know what is available out there and so I don't go out much. I only go to learn at the local centre but when they have holidays I get sad and lonely because there is nothing for me to do.'

'There is no day care or social activities for me and a lot of friends are the same. We just see each other at the mosque.'

'My neighbour gets a minibus to come and pick her up several days a week to take her to a day care centre. No one has offered me such a service. Why does no-one do this for me is it because I can't speak English?'

'We've lost faith in major services and want services from our own community voluntary groups... they are the ones we go to and have done things for us.'

'It seems that the council and the rest of the world do not care for the elderly. What little help is provided by the council if often inappropriate and too late.'

Recommendations:

More needs to be done in terms of promoting racial equality through improving access of services. Age Concern in its paper Black and Minority Ethnic Elders' issues (2002) found that black and minority ethnic elders experience more discrimination in terms of both age and race than other groups within the population. Actions need to be taken by:

1 Developing the services that meet the specialised needs of BME older people.
2 Evaluate the generic services that are being delivered in areas with high BME populations to ensure these groups are actually being reached.

4.2 Type of service required

'I can't speak English so I want somewhere where other people speak the same language as me.'

'I want to go somewhere during the day which is local, it can't be too far, even if there is transport I don't like travelling too far.'

'I enjoy learning, it gives me something positive to do.'

'I take part in English classes and I really enjoy them. It is hard to learn new things but I enjoy trying.'

'We need to have a day care service which has halal food.'

'We need somewhere nice with a socialising room and health advice and keep fit. I may be old but I'm still human.'

'We want activities organised like swimming activities for women only. At the moment the local sports centre say they have women's only days but they have male helpers instead.'

'If they understand our culture they should do it for men and women separately.'

'I want somewhere to go to do healthy things but where its only women and men separate.'

'I want to go somewhere which has a prayer room.'

'I cannot go anywhere on my own. I need someone to take me there. I need to do something because I am too lonely on my own.'

'I need transport otherwise I cannot go anywhere.'

When asked by a member of the council's day care commissioning sector, the majority of older people held that they would like to see a Muslim day care service be established because of the common values this involved such as understanding of prayer times, the provision of halal food and gender segregated rooms.

Recommendations:

A day care service needs to be established which:

1 Employs staff who speak the language of the users
2 Is culturally and religiously appropriate to the needs of the service user
3 Is tailored to the individual needs of the service user
4 Is local to the service user or transport is made available

4.3 Preventative support

Older people felt that preventive measures, such as healthy eating, exercise, a good day out, were important to retain and sustain a good quality of life.

'I know I have health problems because I do not go anywhere to do anything. The doctor told me to go and join a day centre but I don't know anywhere where I can go and enjoy myself. I don't play bingo or dance so I want to do things which I like to do. And I want to make friends at the same time.'

'I feel lonely and sometimes I hate going out because of this. I know this just makes me feel more unwell.'

'Since my husband died I am getting more weak and tired. I would love to go somewhere where I get away from the house and meet new people.'

Research has shown that older people who received services which allowed them to integrate with others, enjoyed higher self-esteem than those who did not.[26] *Providing preventative support falls with the strategic plans of Sheffield's Neighbourhoods and Community Care Directorate Older Peoples Service plan for 2006 - 2007.*[27] *This plan highlights the need to move away from supporting small numbers of people with high dependency at high cost, to early intervention and support services delivered at lower cost and reaching a higher quantity of older people. Thus a day care for elders from ethnic minority communities is an essential Tier 2 service which will provide support for vulnerable adults before they come to crisis point, reducing demand on Tier 3 and Tier 4 specialist services.*

Recommendations:

Work with grassroot organisations to deliver preventative Tier 2 and Tier 3 support for hard to reach groups.
Having more prevention services such as social activities and a good day out, will improve the quality of life for older people. This would prevent Tier 3 and Tier 4 intervention.

[26] Dean, M (2003) Growing older in the 21st Century Economic and Social Research Council
[27] http://www.sheffield.gov.uk/your-city-council/policy--performance/service-plans-200607/neighbourhood-and-community-care-directorate

5. Advice and advocacy support for older people

Key issues which arose in this area included:

- Lack of awareness of benefits/ entitlements
- Lack of advocacy support available
- Quality of advice
- CABs inaccessible
- Language barriers
- Claiming benefits as complex and stressful.
- Home-visits

5.1 Lack of awareness of benefits / entitlements

A conference (Routes of poverty) organised by Burngreave New Deal for Communities Identified a widespread under claiming of benefits, including pension credits. This then led to the pension credit campaign, which aimed to raise awareness amongst the community of the benefit.

'We want advisors to do full benefit checks to make sure we are claiming the full entitlements.'

'I need help with filling in claim forms.'

'I needed support in challenging my rejected benefit claim. I needed someone to help represent me at the appeal.'

'There's no point claiming some benefits because it gets taken away from another direction.'

'There's too much papers, they just confuse me.'

5.2 Lack of advocacy support available

Many of the services find that advice is often confused with advocacy and translation. Many service users expect outreach and translation services as part of the advice service.

'Many places do not provide translators and I struggle to find anyone to take with me.'

'The doctors do not understand what I am trying to tell them what is wrong with me, they give me pain killers and this doesn't help... the translators they provide speak a different kind of dialect to me.'

'I need someone to come with me to the solicitors. They don't provide translators and my advice worker understand my case properly so I try to get her to come with me but she says they are too busy to do this.'

'I need someone to help me argue for my needs. I sometimes go places and I forget what to say or the other person is really clever and they make me feel like I am not entitled to it and I believe them but when I take my support from my community centre with me they don't try to do this because my support worker argues this. But because there is only two part time support workers and everyone wants to see them I have to wait till she is free before I can make an appointment to see her.'

'I don't know where else to go so I go to the community centre and the lady there comes with me to Howden House to sort out my benefits.'

'They provide translators but they don't speak the same dialect as me so I cannot understand whet they say and sometimes they translate wrong.'

Workers often translate for individuals as an additional aspect of their role because service users will go to them as the first point of call. Advice and advocacy that is being provided by community groups are under resourced with at times only one worker to meet the needs of many users. This has resulted in community advice services becoming stretched with funders unwilling to target extra resources in these areas to meet the high demands.

Recommendations:

- BME VCS advocacy services should be adequately funded to fulfil this role which is crucial in promoting older people independence. This service should be readily available to secure the rights and interests of BME older people.

5.3 Quality of advice

'I want the advice centre I use to give me advice properly so it doesn't keep happening but I have to go to the community centre for advice because I can explain to them properly in my language what needs doing.'

5.4 CABs inaccessible

Many expressed concern regarding the accessibility of their local Citizens Advice Bureau. Many said that they have lost faith in major services and want services from their own community voluntary groups. The best routes of support have been when community voluntary organisations are adequately funded to undertake these tasks.

'I've been to the CAB but they didn't have anyone there who spoke my language which is pointless.'

'The CAB is never open. Every time I call to make an appointment I get the answer machine.'

'When I go to the CAB they always seem to be closed.'

Many of the community based advice provisions operate with insufficient funds thus limiting the support they can give which has intensified deprivation.

5.5 Language barriers

Inappropriate advice because of misinterpretation has lead to the failure of benefit claims and confusion which has developed mistrust amongst members of the community.

'When I go into local community based advice service, someone is available with the same language and from my own background, this makes me feel at ease and I can trust them that they will not fill my forms incorrectly.'

'I am from the first generation of people who came into this country and was busy working so my communication is not very good in the English language, I need people who speak my language to support me to access the services I need.'

Many felt that language barriers were an obstruction to them accessing relevant services and felt that this issue needed urgent attention.

Recommendation:

Mainstream services need to recognise the importance of language skilled staff who are able to assist individuals to access all the relevant services.

5.6 Claiming benefits - complex and stressful.

Many older people saw claiming benefits as complex and stressful with rejected claims inducing a sense of being devalued. Making a successful claim appeared to be particularly hard for those with mental health problems and the stress involved could aggravate conditions. Additionally a reluctance to be identified as 'disabled' or 'incapacitated' made some unwilling to claim. However, the system itself was a barrier, seen as unfair, stressful and complicated.

'I always get letters about rent arrears. I don't need this extra stress. I'm old and cannot keep chasing this up all the time. It makes me really depressed that this always happens because of their mistakes. I don't speak English so I go to my local advice centre and they sort it out for me but I'm unwell and this extra hassle makes me even more unwell.'

'I have lived here for over 50 years and I have visited the Yemen nearly every year but this year they rejected my claim for pension credit. This is the first time it has been rejected and they said its because I failed my habitual residency. But why now? I have been living here for over 50 years how can they now say I am not resident here!'

'Why do they reject my claim for housing benefit. Are they saying I am not worth getting it? I cannot speak English so they use this against me because I will not be able to argue my case better so they can use what I should get for other things!'

5.7 Home visits

Home-based advice support was argued by many older people as an essential service which they needed often because they could not access the community centre because of ill health.

'I have problems where I need an advice worker to help me but I cannot leave my home as I am too ill to do this. I need someone to come out and see me at home.'

'I cannot leave my home as I care for my ill husband and I have to call my community centre to come out and help me. I know they don't do home visits so they give me advice over the phone. Sometimes the workers will come to my house to help me but I know they are doing this out of their own goodwill and not because it is their job. This makes me angry because I feel like I am putting them out.'

'I was referred through my local GP for a home-visit as I am housebound an advice worker from the community centre came to my home and dealt with my attendance allowance claim for which I received full entitlement of higher rate, I felt this service, has helped me so much, we should have more home-visiting advice workers.'

SECTION FOUR

Summary of Recommendations

There are number of key issues for providers as well as policy makers and leaders of the Council to address when planning services for older people. It has become clear that there are overarching issues which keep arising across the various areas that were explored. This is deeply disappointing and concerning as it illustrates that older people from ethnic minority communities are not getting the services they need or deserve.

Mainstream public services need to improve their connections in the community to communicate their services to isolated groups by working in partnership with BME VCS organisations and developing effective referral processes.

Public bodies need to promote accessibility of their services which are not just about translating services but about making services known to the targeted user group regardless of race or language spoken. It is about ensuring that information about the availability of the service and the methods of accessing it are tailored to different groups.

Mainstream services need to ensure they develop services that meet the specialised cultural and social needs of BME older people. Existing services which do not have a high take up of BME users need to be evaluated and modified to reflect the needs of this user group.

Conclusion

Equality of access is not just a paper exercise. The local authority needs to look 'inwards' at their own practices as well as 'outwards' to the needs of BME communities in order to progress equality effectively. Access of services should be monitored and evaluated, with models of good practice being shared and developed.

This is not about public services and the voluntary sector competing for public funding to deliver services but about recognising that BME voluntary and community sector organisations can complement mainstream provision because of the specialist, tailored nature of their work.

Public authorities in delivering services to the community need to recognise the valuable strengths of voluntary sector organisations who have a well positioned arm into the community, reaching the most vulnerable and hard to reach groups. Mainstream services need to move away from the notion that voluntary and community sector organisations are there as a threat to the delivery of their own services and instead need to work together to ultimately ensure the needs of elders from BME communities are being reached. Many BME voluntary and community organisations are a vital hub for social and cultural activities which needs to be effectively utilised by mainstream services.

However such partnership arrangements need to also recognise the work that VCS organisations undertake and cannot be developed on an expectancy of voluntary and community sector organisation to undertake the work despite lack of resources and staff performing multiple roles. The fact that the majority of people said that they have lost faith in major services and want services from their local community voluntary groups, highlights that the VCS are better positioned to reach these groups. However, best routes of support have been when such organisations are adequately funded to undertake these tasks.

Appendix 1

Programme

Day: Tuesday 24th of April 2007
Time: 10am - 1pm
Venue: Firth Park Clock Tower

10am- 1pm

10.00-10.30:	Refreshments/ registration
10.30:	Introduction
10.35:	voluntary sector representative
10.45:	PCT representative
10.55:	Older person/speech
11.10-11.40	Workshops:

- Home care
- Day care/ and social activities
- Advice and support.

11.40-11.50:	Feedback from workshops
11.50-12.10:	Questions and Answers
12.10-12.15:	wrapping up
12.15-1.00pm:	Lunch

Appendix 2

Attendees:

119 older people from the Yemeni, Somali and Pakistani communities.

Names of older people who attended:

1. Saleema Jan
2. Gulzar Begum
3. Ghanzanfar Latif
4. Iqbal Latif
5. Khatija Bibi
6. Fazilath Rashid
7. Farzand Bi
8. Zeenat Bi
9. Fatima Bibi
10. Noor Jahan
11. Najama Hussain
12. Shabir Begum
13. Zariyah Jan
14. Fameez Akhtar
15. Asiyah Bi
16. Matloob Hussain
17. Nusrat Jabeen
18. Shamim Akhtar
19. Mohammed Sharif
20. Mohammed Iqbal
21. Fazal Daad
22. Mohammed Bashir
23. Ghulab Din
24. Haji Bostan
25. Mohammad Hanif
26. Mohammad Suleman
27. Mohammed Najib
28. Mohammad Nawab
29. Munsif Khan
30. Farhad Khan
31. Mohammad Aslam
32. Mohammad Bashir
33. Gulbahar Ahmed
34. Mohammad Shaibi
35. Mohammad Shukar
36. Ghulam Mohammad
37. Alam Khan
38. Aurangzeb
39. Naik Alam
40. Mohammad Sarwar
41. Mohammad Qayum
42. Khawaja Matloob
43. Safdar Shah
44. Mohammaed Ismail
45. Mohammad Akram
46. Rashida Bi
47. Shamaim Hanif
48. Mohammad Said
49. Faqir Mohammad
50. Hussain Qassim
51. Abdulraheem Ali
52. Abdirasaq Saleh
53. Aden ali
54. Ali Abdullah
55. Ahmed Salih
56. Said Salah
57. Hadi shaibi
58. Kassim abadi
59. Mehsen nashir
60. Abddul rhman muhsin
61. Saleh Ahmed
62. Ubaid khalid
63. Nel Mohamed
64. Hussain kassim
65. Abdul Hadrami
66. Ahmed Taher
67. Obaid Nasser
68. Ahmed Al-ami
69. Muthana Taleb
70. Abdulrab alyazeedi
71. Saleh obaid
72. Mohamed al haida
73. Mosa ahmed
74. Mohamed Shaibi
75. Mohamed Ahmed
76. Ahmed Dhali
77. Ali tahe
78. Bubak Hussain
79. Munassur Alkheili
80. Saleh Shaibi
81. Kubla saeed
82. Fatima Alami
83. Nageda Nasser
84. Shama Yafai
85. Aisha shaibi
86. Zoa hussain
87. Sofia Blalaid
88. Munzella Abdulla
89. Sahra Hussain
90. Haila alkhail
91. Ulya Munasser
92. Alyn Saeed
93. Safia Qasem
94. Fatima Taleb
95. Amina Ghalib
96. Zahra Qassim
97. Nageda Kassem
98. Mariem ali
99. Marim Nasher
100. Salha saleh
101. Samira Narman
102. Amena Ahmed
103. Faida Alkheili
104. Safia Mohamed
105. Fatima Salem
106. Alya Saleh
107. Zahra Tale
108. Zora Shaibi
109. Miriam Kassim
110. Lola Mushid
111. Seteralla Sanad
112. Mayeed Naji
113. Saleh Muhim
114. Saleh Mohameed
115. Abdulla Ali
116. Mehamed Muhsin
117. Saleh Alhkam
118. Saleh Alaari
119. Amran Soul

With thanks to the following agencies who attended

	Names	Organisation
120.	Sean Davis	South Yorkshire Police
121.	Steve	South Yorkshire Police
122.	Andy Shallice	Area Panel Sheffield City Council
123.	Norah Brown	Primary Care Trust
124.	Jan Sutton	Neighbourhoods and Community Care, Sheffield City Council
125.	Jenny Wood	Sheffield City Council
126.	Angela Rowland	Strategic commissioning for older people, Sheffield City Council

With thanks to the YCA and PCA staff who volunteered at the event:

127. Abtisam Mohamed
128. Anesar Shaibi
129. Abdul Razak Mussalami
130. Rosa Salim
131. Nageeb Kheili
132. Sufian Shaibi
133. Ian Clifford
134. Gulnaz Hussein
135. Fiaz Ali
136. Freeda Sharif
137. Amir Riaz
138. Aisha Akbar
139. Marlene Burrel