Summary of key findings: Open Dialogue Workshops September 2012 to March 2014 From Embedding Ambassadors in Community Health (EACH) Project, East of England LGA May 2014

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1. Executive Summary

As still relatively new clinically-led organisations which came into being following the Health and Social Care Act 2012, Clinical Commissioning Groups (CCGs) gave GPs and other clinicians the responsibility and power to influence commissioning decisions for their patients, based on assessments of the needs of their local populations.

In this report, we explore the views of groups of patients with particular needs from different cultural backgrounds, offering up a series of recommendations for these medical professionals to consider in light of their commissioning roles, and for others in a position to influence service provision or to advocate for patients.

Since September 2012, the EACH Project (Embedding Ambassadors in Community Health) has facilitated twelve 'Open Dialogue Workshops'(ODW's), where 'Third Country National' women who have immigrated to the UK from beyond Europe met with local health professionals in venues across the East of England to discuss their views and experiences of local health services and health care. These discussions brought to light examples of excellent care, as well as various concerns about both the women's physical and mental health and access to services.

There were a number of common experiences shared by the migrant women across all twelve workshops which are grouped in the report under thematic headings, split between areas of satisfaction and dissatisfaction in section 4 of this report.

Interestingly, much of the migrant women's satisfaction and dissatisfaction centred on primary care. Furthermore, despite some women being very recent arrivals, of the 86 asked, 84 are registered with a GP. However, primary care does not appear to be a model of care which is easily understood, or recognised by new migrants and it would seem that they are neither getting the best from this service, nor using it efficiently.

The EACH project team commends these findings to Clinical Commissioners and managers of frontline services with the intention that they be acted upon in order to reduce the unequal access to care and poor health outcomes experienced by this section of the resident immigrant population.

2. Introduction

The EACH Project is a European Union-funded project taking place across the East of England (2011-2014) to further develop the skills and confidence of NHS frontline staff in providing effective and culturally-appropriate healthcare to recently-arrived 'Third Country National' women from beyond the EU. For example, India; Pakistan; Bangladesh; China and Africa. Third Country Nationals are migrant women applying for visas to settle in the UK, mainly in order to marry British citizens.

The focus is particularly on improving their access to healthcare; equipping NHS frontline staff with a better understanding of the healthcare needs of these migrants, and improving migrant health in the longer term.

The Project is run by a team of four part-time staff plus administrative support within the East of England Strategic Migration Partnership, hosted by the East of England Local Government Association.

This report provides an overview of the main findings, or outcomes of a series of twelve 'Open Dialogue Workshops', where 'Third Country National' women discussed their views and experiences of local health services and health care with NHS representatives. These discussions were facilitated in such a way as to encourage the women to share both positive and unsatisfactory experiences in relation to accessing treatment for both physical and mental health issues.

There were a number of common experiences shared by the migrant women across all twelve workshops which are grouped in the report under thematic headings in section 4 of this report.

Taking these key thematic areas, we go on in section 5 to propose a set of recommendations for commissioners and patient advocates.

What is an 'Open Dialogue Workshop'?

In September 2012 as part of the EACH project, a Pilot 'Open Dialogue Workshop' (ODW) was run and facilitated by 'Equality in Diversity', a Luton-based Management, Research and Training Consultancy. They are one of a number of community-based organisations working with the project to deliver capacity-building workshops on intercultural awareness and competence to NHS staff.

The intention of the Luton pilot was to test the 'Open Dialogue Workshop' format, with the aim of bringing together small invited 'audiences' of NHS professionals with local migrant women in order to share views on healthcare services and to identify any possible areas for service improvements.

A further eleven of these workshops took place following the pilot - at least one in each county across the region. Details of where and when these workshops were held can be found in Appendix C.

The workshops were all two hours long and were all facilitated by individuals from subcontractor community organisations recruited by the EACH Project Team. All but two of the nineteen facilitators involved in running the workshops were of minority ethnic origin or faith.

Members of the EACH Project Team identified and invited around ten female NHS representatives from the local area to take part in each of the workshops. The aim

was to attract mainly senior level staff from services likely to be in greatest use by our target group such as Maternity; Health Visiting; Mental Health; GP and other Primary Care Services; Patient Liaison Services; Healthwatch and CCGs. Details of the staff profiles are in Appendix A.

Meanwhile, the facilitators identified and invited around ten recently-arrived migrant women from their own local communities to take part in each of the workshops, and enabled the women to feel comfortable enough to share their views about local health services openly and frankly with a range of NHS service providers. They also appointed interpreters to attend the sessions where appropriate.

Detailed reports of the outcomes of each of these workshops were written up and fed back to the workshop participants for consideration by local healthcare commissioners; providers and others as appropriate, such as Health and Wellbeing Boards. Where possible the outcomes were also fed back to the local migrant women who gave their views via the facilitators.

Having now completed the series of twelve workshops, the EACH team is keen to share this overview of findings, as the project as a whole ends in June 2014.

Each ODW had the following key objectives:

- To explore the barriers to healthcare faced by recently-arrived migrant women from non-EU countries and to identify potential solutions
- To help build positive and lasting relations in the community between the recently-arrived migrant women and local NHS staff
- To give these women the opportunity to have their voices heard as part of the EACH project.

3. Profiles of those attending the workshops

3.1 NHS staff profiles

116 staff attended the 12 workshops from a range of disciplines:

- 12% from Midwifery
- 11% from Health Visiting
- A total of 11% were from PALS; patient experience or Healthwatch including 5% from Community Development or Engagement.
- 5% were in Safeguarding roles
- 4% were in Mental Health roles.

Given the number of times that GP practices and related services came up in discussion with the migrant women, it would have been helpful to have had more staff from practice teams at the workshops. However, we did get an average of one representative per workshop – 5 GPs, 1 Practice Manager and a further 6 delegates from CCGs.
More detail can be found in Appendix A.

3.2 Migrant women's profiles

As the ODWs evolved, we started to collect demographic data from the migrant women attending the workshops, along with information about their English language skills. In summary:

- 38% of the women had been here 4 years or less.
- 29% were from Pakistan, 9.5% each from India and Bangladesh, 8% were from Nepal and 6% from Iraq. All other nationalities accounted for 5% or less.
- Over 82% indicated that they could read and write in English, and even so, 50% are studying English.
- 16% had no children, 36% had 2 and 42% had 3 or more children.
- 97% of them **had** registered with a GP.

More detail can be found in Appendix B

4. Findings in common across the East of England

The migrant women at the workshops gave numerous examples of good, effective and well-received NHS care, as well as sharing their less positive experiences. These experiences provide scope for considering service improvement options in order to ensure patient safety, quality and compassionate care.

All of the women's 'stories' are set out in detail in the individual reports from each of the twelve localities where the workshops took place. Anyone wishing to access a particular report from this series, or to obtain more general information about the workshops or the EACH Project should contact a member of the project team listed in Appendix D.

4.1 Areas of satisfaction

4.1.1 GP's

Although a recurring theme in the workshop discussions were difficulties accessing and getting a satisfactory service from GPs, there were several examples of good practice, as can be seen from extracts from individual workshop reports:

> One migrant woman gave positive feedback about a general health check conducted by her GP, thanks to which her thyroid problems and diabetes were diagnosed. She had not been aware of having these conditions. (**Colchester 1**)

Several migrant women commented that even though they don't speak English they can still access GP services - it is just more challenging logistically. (**Colchester 1**)

In the main, despite some of the difficulties aired at the session, there was a good deal of support for GP services. One woman said that even when she moved house into a different part of Hertfordshire, she asked to stay with her existing GP practice because of her satisfaction with the service provided by the surgery. Another woman said that she has always been able to be seen by a woman doctor. (**Hemel Hempstead**)

4.1.2 Mental health awareness

Whilst the majority of the women's stories about mental health were negative, there was a more positive aspect to note illustrated by the following extract from one of the workshop reports.

Mental health is not identified particularly as a 'health issue' requiring medical treatment in some of the countries of origin of the women participating in the workshop (Sudan and Iraq)**.** Women from such countries and cultures talked about being labelled as 'mad', and left alone to suffer their mental distress. They expressed greater satisfaction with the treatment of mental health problems in the UK, which they found less stigmatizing. (**Norwich**)

4.1.3 Health Visitors, Midwives and School Nurses

Whilst there were examples of dissatisfaction with them, these three groups of health professionals consistently received high levels of positive feedback for being approachable, caring and for delivering good care. This is illustrated by the following workshop extracts.

The majority of the migrant women at the workshop had children under five years old. They said that access to Health Visitors and School Nurses had been easy, and they reported positive experiences. However some of them hadn't realised that they could access School Nurses at any time. (**Colchester 1**)

One of the women reported that her young daughter was not eating very much or then only a limited range of foods. She has been supported in trying to help her daughter by a health visitor who she praised highly as 'a special person, my best friend'. (**Colchester 2**)

4.1.4 Hospital treatment and care

Those women whose children were born in the UK reported overall satisfaction with antenatal care in the UK. The reasons given can be summarised as being because it is free of charge, having scans based on need rather than ability to pay, and being able to access a professional midwifery service rather than just an experienced lay person offering support in the community ('doula'). There were also examples of women who said that they felt better informed about their pregnancies as they were given information with which to make their own personal decisions, rather than having the whole family involved.

One woman who had three children described her first and last experiences of maternity care as ‘good’. Another said that she had a supportive Health Visitor who had supported her a lot and helped when putting in a complaint about a painful antenatal internal examination. (**Hemel Hempstead**)

Midwives now routinely ask women about their relationships with their husbands. This is to identify risks of domestic abuse/violence. (**Luton 1**)

A pregnant woman with diabetes accessed the Obstetrician early in her pregnancy and experienced good liaison between the Obstetrics and Diabetes services teams. (**Luton 1**)

One of the women had a fall and was admitted to hospital in Watford having sustained a head injury, resulting in intermittent bleeding. She described receiving excellent care from all staff – from nurses to consultant. She was particularly grateful for this care, having been admitted without family help, as it had happened during the day when they were out at work. ‘They really made me feel at home’. (**Watford**)

4.2 Areas for service improvement

4.2.1 <u>Communication difficulties in accessing care and appointments, and misunderstanding the GP consultation process</u>

In many cases, this was in relation to accessing GP appointments. However, some women were also told to only come with one health problem at a time, so there was a tendency to return to the GP time and time again with unresolved health concerns.
The following workshop extract gives a fairly typical flavour of problems encountered with appointments systems.

One workshop participant follows guidance and makes an early call to the surgery to make an appointment, and is happy to do this as her children are able to interpret for her. However, her surgery offers a ‘triage’ system and unless her children arrange an urgent appointment for her, the surgery has to call her back. As this happens later in the day when her children are at school, she does not understand what the surgery is saying to her so has to wait for her children to return to make a further follow up call. (**Ipswich**)

4.2.2 Misunderstanding the needs of migrant women

There was a general feeling from the migrant women at several of the workshops that healthcare staff did not understand, or necessarily feel that they needed to understand other cultures and/or their associated religious beliefs and practices[1]. There was also a feeling that, in relation to some Asian women, it would be helpful for staff to understand the difference between forced and arranged marriage as well as being alert to the potential involvement of the wider family in incidents of domestic violence, including 'in-laws', as well as cultural perceptions around services such as sexual health and contraception.

One migrant woman talked about having been given anti-depressants when she was really trying to say that she was experiencing domestic abuse. She wasn't aware of any Asian counsellors. (**Bedford**)

This woman's situation appears all the more poignant bearing in mind the Care Quality Commission's 'Count me in 2010 Census' which talked of the statutory role of proposed GP consortia to promote equality and reduce inequalities in healthcare, and the role of Public Health in addressing the socio-economic disadvantages faced by Black and minority ethnic communities, which adds to the burden of mental illness in these communities.[2]

4.2.3 Insufficient access to trained, skilled interpreters or bi-lingual healthcare staff[3]

The issue of learning to speak and write in English in order to avoid miscommunication was raised in the workshops, but was found to be a complex issue, with almost all the migrant women either being in the process of learning, or wishing to learn. However, the availability of locally accessible classes appeared to be extremely limited in some areas. There was some concern that appointment letters inviting women for screening or other appointments don't seem to be produced with the benefit of background intelligence from GPs, such as the need for an interpreter to be present. So if women don't know that they will have an interpreter at a hospital appointment, they will not attend until they can bring someone from the family with them. This leads to women

[1] For example, in Islamic hygiene tradition, nails and hair from private parts should be cut within 40 days. A carer reported that she was unable to arrange for this service for her dependant father in law for 3 months leaving him with long toe nails, which as he wears no shoes, made him vulnerable to knocks and injuries, as well as the mental turmoil of not complying with his religious obligations.

[2] http://www.cqc.org.uk/content/count-me-2010-census

[3] Some of the women's experiences relating to miscommunication were extremely stark. For example a participant described her husband attending his GP complaining of stomach pains and being told that it was a heart problem, and receiving care based on that diagnosis. Only when he was seen by a Kuwaiti national doctor did they converse in Arabic and he was able to make it clear that the problem was stomach related. He was then diagnosed with inoperable stomach cancer and died three months later.

not attending their appointments and running the risks to health of later presentation for care.

In addition, the recruitment of more bi-lingual health professionals was suggested at workshops in those parts of the region with highest levels of non-English speaking Black and Minority Ethnic populations. This was seen as a cost-effective option[4] which could be enhanced by identifying volunteer bi-lingual health champions for specific health improvement campaigns – for example family planning, breastfeeding or diabetes as described in one workshop report as follows:

One migrant woman was told at a screening appointment that she was diabetic, but she hadn't really been given any information. She subsequently received more detailed advice and support from her own community members. (**Colchester 1**)

Amongst the health professionals, not all were clear about how to have an interpreter present and most were not aware that telephone interpreters were an option as well as face-to-face. (**Hemel Hempstead**)
While it was highlighted by one woman about the responsibility of people living in the UK to learn English, another said 'You can fall ill before you have learnt enough English'. Amongst health professionals there were mixed views about what interpreting was suitable, available and affordable. (**Southend**)

A woman from Turkey explained that while visiting Turkey over the summer she had an episode of ill health which resulted in her being admitted to hospital for six days … she had a range of tests undertaken. The diagnosis …was that she has MS. She was given the medical papers, including brain scans, to bring back …to the UK with the instruction that she should be referred to the hospital as a matter of urgency. She has seen her GP, and despite asking for one, no interpreter was present, and as she did not completely understand what happened in that appointment, she does not know whether the referral to the neurologist has been made. She has not been asked to get the Turkish medical documents translated ... Her GP asked her to take paracetamol and prescribed anti-depressants … However, … because they made her drowsy, as she has two small children to care for, she … stopped taking them ... As she feels like she does not know what is going on, when she moves house within Colchester, her intention is to change GPs. (**Colchester 2**)

4.2.4 <u>Lack of translated materials</u>

One of the main issues raised by the women in relation to this issue was test results letters only being written in English & information leaflets in GP surgeries only being available in English.

Women reported feeling uninformed because of reliance on leaflets for imparting information, which in many cases are written with too high a level of English to be easily understood. One described feeling afraid when in hospital, being linked up to a device and not understanding why. (**Hemel Hempstead**)

[4] See Census 2011 data for supporting evidence

4.2.5 Insufficient availability of female GPs and hospital consultants - particularly on labour wards.

Several women raised the issue of antenatal and postnatal care. The women did not like having male doctors examine them and one lady had been told in labour ‘if you don’t see a male doctor you could die’. The women also said that postnatal care was not personal; you are now expected to visit the professionals instead of them visiting you.

According to some of the women, the absence of adequate numbers of female health professionals was a barrier to accessing care effectively. It is widely known that many ‘traditional’ South Asian women do not like to be physically examined by male NHS professionals. A female GP at the workshop said that it is difficult for women to become consultants especially if they want to have families, but this is improving. (**Cambridge**)

4.2.6 Complexity of NHS services

Many of the migrant women’s stories leave an impression of an NHS which they find generally difficult to ‘navigate’. In particular, whenever they felt that timely and effective primary care had not been available, there seemed to be a real sense of dismay about where else to go for help.

A woman talked about the care she received when her son was ill with asthma. She took him to the GP who examined him and said ‘I wouldn’t worry’ - she felt he didn’t take her concerns seriously. They returned home and his condition deteriorated and she called an ambulance. The doctor at A & E could not understand why the GP had said that her son was not unwell. (**Norwich**)

4.2.7 Delays in accessing secondary care

Although most of the migrant women’s concerns seemed to be about accessing effective primary care, there were also many accounts of unsatisfactory secondary treatment and care, particularly in relation to perceptions of treatment being delayed.

One woman reported how her sister in law had only been seen by a specialist two to three months after the initial referral. By this time, the leukaemia could not be treated and she died 18 months later, in her late 40s. (**Peterborough**)

“My daughter was suffering from tummy pain and was seen and treated by a Paediatrician at A&E, but it didn’t help her. But when we wanted to see a Paediatrician again, the only appointment available was after four months later. I think that is too long period to leave my 7 year old daughter in pain. So Paediatric appointments must be available sooner, and as and when required.” (**Luton 2**)

4.2.8 Limited awareness of the existence or benefits of screening services

Health professionals need to know more about the communities they work with in order to explain the different services on offer in a culturally appropriate way. For example, if first cousin marriage is routinely practised, information should be made

directly available to couples to ensure that screening opportunities are taken up. Breast and cervical screening services also need to be better understood in order to ensure higher take up by migrant women. The following workshop extract illustrates the problem in one area of screening:

> Pregnant women who are married to their cousins are not automatically given information about opportunities for genetic screening. Lack of information about who they should contact for genetic screening is a barrier to access. (**Luton 1**)

4.2.9 <u>Insufficient comprehensive care planning</u> to meet the healthcare needs of migrant patients, and to allay their fears as illustrated by the following workshop extract:

> One of the interpreters at the workshop shared a story about a migrant patient she had been asked to interpret for who had been given six months to live, and her notes said that she could not be given cardiopulmonary resuscitation. But other than that she did not appear to have a comprehensive care plan, and the interpreter was concerned, for example that there was nothing stated about treatment for infections. This led to a group discussion about palliative care for members of minority ethnic groups and whether the concept and status of 'power of attorney' was being fully explained to both patients and relatives. (**Colchester 1**)

4.2.10 <u>Limited access to culturally appropriate health improvement opportunities</u>

> Many of the women felt that they should visit their GPs as sparingly as possible despite the many health problems they experience, thus potentially missing out on health promotion advice and opportunities for primary prevention. This is because they do not want to be perceived by health professionals as hypochondriacs. (**Cambridge**)

5. Recommendations

Given that the findings outlined in section 4 above are overarching findings in common across all twelve Open Dialogue Workshops, they should provide healthcare commissioners with a powerful message and call to action on serving migrant women and families. Arguably it would seem that relatively small changes would make services appear more approachable and responsive to this group of women, and possibly also to some other groups within the wider community.

Our recommendations are therefore as follows:

5.1 Give time to supporting patients through better communication

Make sure that patients have enough time – preferably a double appointment for those with language needs – along with support to ensure that their health issues are understood and managed effectively.

5.2 Develop the cultural competence of frontline staff

There is ample evidence from the very positive responses of staff to the 'hands-on' cultural awareness workshops provided for the EACH Project by minority ethnic organisations, that there is still scope for much more of this work across the region.

In winding down the EACH Project at the end of June 2014, we will be placing a number of key legacy guidance documents on our website to help anyone in the NHS wishing to organise such a workshop.[5] See Appendix D for details of how to access these.

5.3 Improve access to interpreters, bi-lingual staff and patient advocacy, and encourage patients to use all of these.

Clinical Commissioning Groups should produce guidance to ensure that frontline staff know when and how to book a professional interpreter so as to give both an efficient and cost effective service.

Make sure that appointment systems such as triage telephone appointments don't leave those with language needs unable to access services.

Work with local community and faith-based organisations to inform people about their rights to "treatment free at the point of delivery" and about patient advocacy organisations, in ways and formats that they will understand.

The aim should always be to encourage timely access to effective treatment and care.

5.4 Make more translated materials available

Knowing the demographics and cultural make-up of your service area is vital to inform whether or not you offer translated materials. There are parts of the region where new South Asian arrivals are not literate in their mother tongue, so producing translated materials is of no benefit to them. It would be better to produce plain English, easy-read or picture and diagram rich information which then is of benefit to the wider community as well.

However, where you know that translated materials will be accessible to your target group then they will help to encourage women to come forward for treatment, and should be used in appointment letters and leaflets.

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[5] http://www.eelga.gov.uk/support-services/migration.aspx

5.5 Be aware of the reluctance of some migrant women to be examined by male staff.

Where possible, examination and treatment by a female staff member should be offered to these patients. If that is not possible, time should be taken to explain what needs to happen during the examination, and to ask the patient what could be done to ease the situation from their point of view.

5.6 Make 'navigating' around the NHS less complex

For recently-arrived migrants still acquiring English, accessing the correct service on a first, or even subsequent attempts can prove difficult. Not only can this compromise health – both theirs and the wider community - but it can also cause financial pressures to services. Find out more from these women about what would help simplify information about how the system works and act accordingly.

5.7 Review access to secondary care by migrant women and families

Review the ethnicity of patients on waiting lists for secondary care, and take action to ensure that they are seen and treated equitably. Explain the secondary care appointments process clearly to allay patients' fears about possible delays.

5.8 Promote the uptake of screening services to migrant women

This needs to include antenatal genetic screening for couples as well as breast and cervical screening.

As with most awareness raising, it is advisable to work with existing local community and faith-based organisations and patient advocacy organisations, using methods and formats that are culturally acceptable.

5.9 Ensure that migrant patients with limited English have comprehensive care plans

Patient understanding of, and agreement to these care plans need to be ensured, including their wishes in relation to culturally appropriate end of life and palliative care.

5.10 Make health improvement opportunities available and promote their uptake in the community.

The provision of culturally appropriate health improvement opportunities such as women-only swimming and exercise classes should be part of commissioning plans. Given that many women get their information from community networks, promotion of these kinds of opportunities needs to be carried out via local groups and language classes.

Health issues such as diabetes were mentioned repeatedly at the workshops, particularly by South Asian women. Culturally appropriate diet and diabetes awareness guidance needs to be given so that women can apply the guidance at

home.[6] The Desmond programme is a good example of a culturally appropriate health improvement programme, for example offering guidance to those with type 2 diabetes wishing to observe Ramadan.[7]

6. Sharing the Open Dialogue Workshop outcomes at national level

It is the intention of the Project Team to seek opportunities to share the outcomes from these workshops widely with leading figures known to have a key role in healthcare quality and equity at national and regional level. This is something that we did in July 2013 when we disseminated an interim report on the eight ODWs that had taken place up to that point.

Our initial contacts will be with key individuals from the following organisations:

- Care Quality Commission
- Department of Health (Patient & Public Affairs)
- Healthwatch UK
- National Association of Primary Care
- National Equality & Diversity Council
- NHS England (Health Inequalities; National Inclusion Health Board & Patient and Public Voice)
- NHS England Midlands & East
- Public Health England
- Race Equality Foundation
- Race for Health
- Royal College of GPs

However, we would be grateful for further suggestions. So anyone wishing to add to this list should contact a member of the EACH Project team listed in Appendix D.

[6] *See for example* Healthy Eating for South Asians - Healthy Diet Tips.
[7] // DESMOND // //

Appendix A

NHS staff profiles

NHS delegates' roles	NHS Trust/Organisation	Number of delegates
Midwifery and maternity services	Cambridge University Hospital Trust (Addenbrookes) Luton & Dunstable Hospital Ipswich Hospital Peterborough and Stamford NHS Hospital Trust Norfolk & Norwich University Hospital West Hertfordshire Hospital Trust Colchester Hospital Bedford Hospital North East Essex CCG	14
Health Visitor	Ipswich Community Services Iqbal Children's Centre, Peterborough Cambridge & Peterborough Foundation Trust Norfolk Community Health and Care Trust East Coast Community Healthcare CIC Anglian Community Enterprise (ACE), Essex South Essex Partnership Trust (Bedford) Hertfordshire Community NHS Trust Cambridgeshire Community Services	13
Quality, Safety & Patient Experience	PALS Ipswich Hospital Hertfordshire Partnership Foundation Trust Hertfordshire Community Health Service	8
Adult or children safeguarding	Bedfordshire CCG NHS Luton/CCG Ipswich Hospital NE Essex CCG Safeguarding Essex, Essex County Council	6
Community Development worker	Cambridge and Peterborough Foundation Trust Livewell Suffolk Southend MIND Healthwatch Hertfordshire South Essex Partnership Trust (Bedford) Colchester MIND	6
Mental Health Practitioner / Clinical Psychologist / Social worker	Norfolk & Suffolk Foundation Trust CAMHS, Essex Hertfordshire Partnership Foundation Trust Dacorum Community Mental Health Trust South Essex Partnership Trust (SEPT)	5
GP	Suffolk Community Refugee Team, Marginalised & Vulnerable Adults (MVA) Service NHS Southend CCG Bedford CCG	5
Patient Representative / Experience	Cam Health, local commissioning group North East Essex Health Forum The Community Voice, Hertfordshire	5

	Luton and Dunstable Hospital South Essex Partnership Trust (Luton)	
Director / Manager/ Associate Director	Public Health South Essex Partnership Trust (Bedford) Healthwatch Bedfordshire Luton and Dunstable Hospital	5
Consultant / Service Lead / Registrar	Public Health	4
Executive Member	Healthwatch Suffolk NE Essex CCG Herts Valley CCG Healthwatch Bedfordshire	4
Engagement Manager / Project Manager / Delivery Manager	NHS Norwich CCG Bedfordshire CCG North East Essex CCG West Hertfordshire Hospital NHS Trust	4
Breast Care nurse / Radiographer	Peterborough and Stamford Hospital Trust West Hertfordshire Hospital Trust Cambridge University Hospital Trust (Addenbrookes)	3
Children's Services / Paediatrics	South Essex Partnership Trust ACE Luton & Dunstable Hospital	3
Matron / Senior Nurse	Millfield Medical Centre, Peterborough Southend Hospital West Hertfordshire Hospital NHS Trust	3
School Nurse	Cambridge Community Services Suffolk County Council	3
Diabetes Lead/Nurse	Cambridge Community Services, Bedford Hospital	3
Support Worker	Suffolk Community Refugee Team, MVA Service Norfolk Community Health and Care Trust	2
Physiotherapist	Cambridge University Hospital Trust (Addenbrookes)	2
Complaints advocate / advice worker	Healthwatch Southend	2
Sexual Health Adviser	St Alban's City Hospital ACE	2
Health Protection	NHS Luton/CCG	1
Speech and Language Therapy	Cambridge Community Services	1
Dietician	Cambridge Community Services	1
MacMillan Nurse	Peterborough and Stamford Hospital Trust	1
Commissioning and Research Manager	Healthwatch Essex	1
Orthoptist	Cambridge University Hospital Trust (Addenbrookes)	1
Eating disorders	South Essex Partnership Trust	1
Children and Maternity Commissioner	NE Essex CCG	1
Practice Manager	London Road Surgery, Bedford	1
Occupational Therapist	Mental Health Project, Colchester	1
Health Improvement Lead	ACE	1
Lead Nurse, Emergency Care	West Hertfordshire Hospital Trust	1
Resources Manager	Healthwatch Hertfordshire	1
Communication Lead	Luton CCG	1

Appendix B - Migrant women's demographic profiles[8]

		X or ✓	Comments
Where were you born?	Pakistan	24	
	India	8	
	Bangladesh	8	
	Nepal	7	
	Iraq	5	
	China	3	
	Congo	2	
	Saudi Arabia	2	
	UK*	2	
	South Africa	2	
	Tanzania	2	
	Kenya	2	
	Other	13	
What is your age?	16 - 24	9	
	25 - 30	20	
	31 - 35	20	
	36 - 40	10	
	41 +	27	
How many years have you lived in the UK?	1 or less	13	
	2	10	
	3	5	
	4	5	
	5	5	
	6	4	
	7	5	
	8	6	
	9	4	
	10+	29	
Can you read English?	Yes	71	
	No	13	
Can you write English?	Yes	73	
	No	13	
Are you learning to read and write English?	Yes	41	
	No	41	
How many children do you have?	0	13	
	1	5	
	2	35	
	3+	30	
Are you registered with a GP?	Yes	84	
	No	2	

[8] The numbers of responses to these questions varies because some of the migrant women left some answers blank.

APPENDIX C

Open Dialogue Workshops – dates and venues

Area	Date of workshop	Venue
Luton	12th Sept 2012	Dallow Learning Community Centre, Luton
Cambridge	27th Nov 2012	Abbey Meadows Community Centre
Ipswich	27th Nov 2012	Manor Ballroom, Ipswich
Peterborough	6th Mar 2013	Gladstone Park Community Centre
Norwich	2nd May 2013	Age Concern, Norwich
Hemel Hempstead	14th May 2013	Bennetts End Community Centre
Southend	3rd Jun 2013	Southend Association of Voluntary Services
Colchester	13th Jun 2013	Fresh Beginnings Migrant & Refugee Support Centre
Bedford	4th Oct 2013	All Saints Parish Rooms, Queens Park
Colchester	30th Oct 2013	Fresh Beginnings Migrant & Refugee Support Centre
Watford	2nd Dec 2013	Holywell Community Centre
Luton	14th Mar 2014	Centre for Youth & Community Development

Appendix D

Accessing local Open Dialogue Workshop reports

Anyone wishing to read the detailed findings of a local report produced after an ODW in their geographic area should contact a member of the EACH project team.

However, please note that the EACH project will end on 30th June 2014. Any documents relating to the project will then be available from our website: http://smp.eelga.gov.uk/

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