Primary Concern

Access to GP Practices for Black and Minority Ethnic communities in Kensington, Chelsea and Westminster

A Report by the BME Health Forum
June 2008

Cover image: Meerat Kaur © BME Health Forum 2008

Acknowledgments

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This report was written by Martyn Brookes, an independent researcher. This research project was managed by Amjad Taha, the manager of the BME Health Forum.

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Executive Summary

Significant concerns about BME communities' access to GP services have been a feature of the findings of the BME Health Forum's work over the years. This report was commissioned to look into this in detail, to understand the barriers to GP access and identify how to overcome them. Other national and local reports, such as the 2007 national GP patient survey and the recent Department of Health report - "No Patient Left Behind" have also identified primary care access as major issue of concern.

This report highlights three main issues:

- A substantial minority group of BME communities are very dissatisfied with the process of registering with a GP and making appointments.
- A large number of patients are dissatisfied with their relationship with their GP and practice staff.
- Communication problems, caused by language and cultural barriers impede on the doctor-patient relationship. Interpreting services are not widely available and waiting for an interpreter to be booked limits access to services. Many people use unofficial interpreters, including children thus jeopardising the clinical outcome of the consultation.

From our findings it is clear that GP practices need to become more aware and flexible in responding to different patient needs in order to provide an equitable service and that the consequences of not doing so is poorer quality of services and poor health outcomes. Additionally, unsatisfactory relations between patients and providers, regardless of cause or responsibility, are likely to lead to increased visits and increased costs. This will either come through revisits prompted by lack of confidence in diagnosis, by inappropriate presentation at A&E or by patients presenting later in the course of their illness and therefore needing more care. It is therefore in everyone's interest to improve relations with all patients. The use of unofficial interpreters has implications for patient safety and clinical governance.

Our key recommendations demonstrate that it is the responsibility of all NHS stakeholders to address the issues highlighted in this report:

- The PCTs should ensure that they commission primary care services which are flexible and responsive to the needs of all groups. They should also commission community groups and the BME Health Forum to develop projects to improve access.
- The PCTs should undertake a full joint review, in partnership with all other stakeholders, to revise/establish standards for interpreting support across KCW.
- Practices should use patient groups/panels, local community groups and the BME Health Forum as a route for improving their understanding of local communities and communities' understanding of NHS services and practices.
- The BME Health Forum should work with practices to identify and develop good practice in relation to providing interpreting support.
- The BME Health Forum and community groups should actively promote the availability of interpreting services to their members

A summary of our detailed recommendations can be found in the next section.

Overall Recommendations

The recommendations of this report have been underpinned by the following **principles**:

- As commissioners, the PCTs should ensure that commissioned primary care services are flexible and responsive to the needs of all groups. They should also commission community groups and the BME Health Forum to carry out their responsibilities in implementing the recommendations set out in this report.
- The GP practices should be more responsive to the needs of their diverse patients. Providing a flexible and responsive service will improve equity in healthcare.
- BME community groups should seek funding to develop community-based projects for improving access to primary care services for their communities.
- Alongside their lobbying for getting the BME issues on the agenda, the BME Health Forum and community groups should use their knowledge of BME communities to propose solutions to overcome the barriers to access.

Specific key recommendations

a) Registration

- The PCTs should provide guidance for practices on entitlements, requirements and documentation.
- Practices should ensure fair and transparent processes in registrations by putting in place procedures which are based on this guidance.
- The PCTs should work with the BME Health Forum to produce fact-sheets for communities (including PALS as a route to raise concerns).
- The PCTs to introduce a system requiring the reporting and referring of anyone who has been refused registration to PALS.

b) Interpreting

- Practices should seek the feedback of their patients on interpreting services.
- The BME Health Forum should work with practices to identify and develop good practice in relation to providing interpreting support.
- The PCTs should produce/reissue guidance and arrange training for Practice staff on working with interpreters.

- Practice should consider fluency in a community language as a desirable criterion when recruiting practice staff.
- The PCTs should have the provision of interpreting services as a key requirement in all future commissioned services.
- The BME Health Forum and the community groups should encourage patients to report dissatisfaction with service, either through a system in the community sector or through PALS.
- The issue of patients bringing their children to interpret needs to be addressed as a matter of urgency. Practices must refuse to treat patients who bring their children to interpret for them, except in emergencies.
- The PCTs should lead a full joint review, in partnership with all other stakeholders, to revise/establish standards for interpreting support across KCW.

c) Relationships

- The PCTs should review/develop training programmes for practice staff to ensure that Knowledge & Skills Framework (KSF) competencies for Equality & Diversity are effectively integrated.
- Practices should monitor their patient lists and take steps to ensure that their patient groups/panels reflect the diversity of their patient population.
- Practices should use patient groups/panels, local community groups and the BME Health Forum as a route for improving their understanding of local communities and communities' understanding of NHS services and practices.
- The PCTs should require practices to undertake patient profiling.
- The BME Health Forum should work with practices to identify and develop good practice.
- The PCTs, the BME Health Forum and the PBC Clusters should jointly produce fact-sheets for community groups on NHS Primary Care and how it works.
- Community groups and the BME Health Forum should actively disseminate and distribute these fact-sheets.

Section 1: Introduction

Background

Access to NHS services for BME communities has often featured as a major health concern in the BME Health Forum work over the years. In 2006, the Forum report “Minding the gaps” identified that access to GP services in particular as being the core of BME dissatisfaction with NHS services in Kensington, Chelsea and Westminster.

This report builds on the findings and recommendations of ‘Minding the gaps’ and aims to provide a better understanding of the barriers that BME communities face when accessing GP practices and possible solutions. It is the conclusion of an 18-month research project ‘Access to GP Practice’ that involved interviewing 55 patients and 16 health professionals in KCW.

The purpose of the Access to GP Practices project was to improve access to GP services through addressing three key issues: registering and appointment-making; the quality and availability of the interpreting services; and the interaction between BME patients and GPs and other practice staff.

To achieve this, the Forum involved all key stakeholders in the development of the project from the outset. The research has sought the views of GPs, practice managers, Chairs of the Clinical/Professional Executive Committees, Chairs of the PBC Clusters as well as BME patients. The aim was to ensure that the views of all those involved were represented. Therefore, the findings and recommendations of this report reflect what the various stakeholders perceive to be the best way forward.

Legislative & Policy Context

This project, as part of the work of the Forum, came about in the light of recent legislative and national and local policy developments that require PCTs and NHS providers to improve access to services and reduce health inequalities. Some of these legislative and policy requirements are:

Race Relations Amendment Act 2000

This Amendment, resulting from the Stephen Lawrence Enquiry, adds to the general duty to eliminate racial discrimination and promote equal opportunities, by specifying the creation of a Race Equality Scheme aimed at preventing ‘institutional racism’, and ensuring that the UK’s racial diversity is properly represented at all levels. The aim is to help public authorities provide fair and accessible services, and to improve equal opportunities in employment. The Act intends that race equality shall be ‘mainstreamed’ within the organisation; in other words, that attention to equality is built in to all its policies, at all levels and at all stages. All Public Bodies are required to produce a Race Equality Scheme outlining their process to improve delivery and equality in their services, and to involve local communities in this process.

Improving GP access for all

Health Secretary Alan Johnson has committed to creating more responsive and accessible primary care for black and minority ethnic (BME) groups, following the recommendations of two reports[1] published on 22nd May 2008.

The reports’ findings are published in response to issues raised in last year’s GP patient survey. In response, the Department has announced the creation of a national support programme, led by Dr Michael Warburton, to work with the NHS and with GP practices to drive forward improvements in GP services.

The programme brings together existing work to extend GP opening hours and to invest £250 million in establishing additional primary care services that increase access and patient choice, together with fresh action to ensure that these additional services create more responsive and accessible primary care for BME groups.

Alan Johnson said: "We recognise that while the overwhelming majority of patients are happy with their experience of GP services there are pockets of dissatisfaction where improvements can be achieved - particularly in some BME groups.”

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[1] The two reports published are:

* 'No Patient Left Behind: How can we ensure world class primary care for Black & Minority Ethnic people?' Report of the group chaired by Professor Mayur Lakhani CBE.

* 'Report of the National Improvement Team for Primary Care Access and Responsiveness' led by David Colin-Thome, National Clinical Director for Primary Care.

In addition to the above, there are numerous policy developments that have emphasised the need to improve access to services for BME communities. Examples of these include **the NHS Plan and National Service Frameworks**

In terms of the **local agenda**, improving access to primary care services and reducing health inequalities are priority objectives for the two local PCTs.

Setting the context for this research

Following the Black Report (1988) and the Acheson Report (1998), addressing social inequalities in health is now entrenched in many performance targets of the National Health Service (NHS). The Acheson Report recommended that the NHS has several interlinked responsibilities in relation to health inequalities. These were:

1. To provide equity of access to effective health care.
2. To work in partnership with other agencies to improve health and tackle the causes of health inequalities.
3. To provide professional leadership and to stimulate the development of health policies beyond the boundaries of the NHS.

There is a substantial body of literature showing the existence of inequalities in health status. However, less is known about the existence of inequalities in healthcare; especially inequalities relating to quality measures such as access.

There are a variety of indicators which provide evidence that healthcare is inequitable in key quality related factors such as uptake, access, and provision; however the picture is complex. Dixon-Woods (2005) and colleagues reviewed the literature of vulnerable groups and access to healthcare. Although there were no firm conclusions that there are substantial inequalities in access between groups, they did cite some evidence that suggests the existence of differences in some specific situations. In another review of the literature, Dixon et al (2003) suggest that, in relation to their need, lower SES (socio-economic status) groups use health services less than the higher SES groups. This is the case for access, uptake, and consultation time.

In 2006, the BME Health Forum published a report “Minding the gaps – Are BME groups partners or substitutes in health provision?” which identified that access to GP practices was a major health concern for BME communities in Kensington, Chelsea and Westminster. This report builds on the findings and recommendations of that report and aims to provide a better understanding of the barriers that BME communities face when accessing GP practices and possible solutions.

The issues of BME access to GP services has also been reviewed in a recent Department of Health report - "No Patient Left Behind: how can we ensure world class primary care for black and minority ethnic people". The report builds on findings from the 2007 national GP patient survey, where it was found that substantial numbers of patients with BME backgrounds were less satisfied with GP access than the general population. The report proposed four main inter-linked reasons for these lower levels of satisfaction:

- There are communication problems caused by language and cultural barriers
- The expectations of BME patients are different
- The disease burden is greater in the BME communities
- The quality of GP services is too variable

The points raised by the report show that it is not only the BME communities who are adversely affected and have lower satisfaction; the disease burden is high in deprived areas and variable quality affects all. However, the unique characteristics of ethnic groups offer potential explanations for barriers for this particular sub-group; particularly the first two points of communication problems and the expectations of BME patients, are examples of these characteristics. These explanations can be used to guide interventions to improve access to health care.

Mold and colleagues, in their review of qualitative literature relating to stroke care, argued that ‘the ways in which professionals and patients view themselves and each other influences their interaction, and in turn, the delivery and demand for services’ (Mold et al 2003). Also, there is some evidence which suggests variation exists in patient’s willingness or ability to engage with providers; Saha (2000) has demonstrated some ethnic disparities in this willingness or ability to engage.

In addition, the trust and perception of quality of service has been shown to vary by ethnic group (Doescher 2001). Adamson (2003) suggested that inequalities in use of healthcare is not related to the patient’s behaviour, but in the characteristics of the health care provider. The combination of this evidence suggests that there may be factors in the patient-provider interaction that limit the quality of health services to particular socio-demographic groups, and to BME groups in particular.

In the light of this evidence, reduced access to services of BME groups in comparison to the general population may occur as a result of issues such as language barriers, lack of confidence and lack of knowledge of the system.

In summary, issues such as lack of access, low uptake, and dissatisfaction are not unique to the BME population, but they are prevalent within the BME population. There should be efforts to improve the situation for all vulnerable groups of patients, such as those from lower socio-economic backgrounds, BME groups, and people with learning disabilities, as well as parallel efforts to address the unique situations of each of these groups.

What this points to is the need for primary care to be flexible and responsive to the needs and characteristics of the different population groups. Having an understanding of those groups is key in this.

Section 2: Project aims

The overall aim of this project is to improve access to General Practitioners for BME groups, through investigating issues around

- Registering and making appointments
- Interpreting services
- Relationship between GPs (and other practice staff) and patients

This report will analyse these issues from the different perspectives of commissioners (PBC Clusters, CEC/PEC), providers (GPs and practice managers), and patients.

Recommendations will be made to four different stakeholders:

- Commissioners of services
- Providers of services
- Community groups and patients
- The BME Health Forum.

Recommendations will be made separately for each of the issues being investigated. Overall recommendations will also be made.

Section 3: Methods

Project Steering Group

The project was initiated by the BME Health Forum. A sub-group of the BME Health Forum Steering Group, referred to as the Access to GPs Project Steering Group, was established to guide the project. The group was made up of representatives from the local BME community groups, PCTs, voluntary sector organisations and some patient representatives.

The objectives of the research project were:

- To understand the systems involved in registering with GPs and making appointments, whilst considering how the specific characteristics of the BME communities may impact upon their use of health services.
- To assess the confidence that various stakeholders have in the interpreting services; and to understand how these variations impact upon the use of health services.
- To consider the quality and nature of the relationship between GPs and patients; to understand any relationship issues that may impact upon the provision and uptake of health services.

Data collection tools

This research was conducted using six different data collection tools on six different groups of stakeholders. These groups were:

- Patients
- General Practitioners (GPs)
- Practice managers
- Chairs of PBC Clusters
- Clinical/Professional Executive Committee Chairs (for each PCT)
- BME Health Forum Steering Group and patient representatives

Each of the above involved trained researchers from local community groups administering a semi-structured questionnaire. The exception was the BME Health Forum Steering Group who attended a focus group session.

The semi-structured questionnaires had a deliberate mix of quantitative and qualitative elements. The latter was important in allowing participants to elaborate on their responses, adding further detail to the issues. The questionnaires were developed by the Project Steering Group.

The focus group structure and question schedule was designed by the author of this report, an independent researcher. The issues covered in the focus group were selected after preliminary analysis of the other data sources. In this way, the experience and opinions of the BME Health Forum Steering Group and selected other participants were collected objectively and utilised.

The Focus Group looked into the context of responses, getting a deeper understanding of the results from the questionnaires. It examined the differences in expectations between the patients and the health professionals, uncovering reasons for differences or the existence of any prejudice or pre-conceived ideas. It also allowed the researcher to gauge how representative the results from the other data sources were of the wider BME population.

Participant sample

The sample for the health professionals (GPs, practice managers, PBC Chairs, and CEC/PEC Chairs) was selected opportunistically. GPs and practice managers were selected through contacts at the BME Health Forum. All CEC/PEC Chairs and PBC Cluster Chairs were invited.

Requests for meetings were sent out and those who agreed were interviewed; none were refused interviews. All CEC/PEC Chairs and PBC Cluster Chairs agreed and were interviewed. Of the invites to practices (GPs and their practice managers), 12 refused or did not respond, and five took part (5 GPs and 5 practice managers).

The patient sample was designed to capture the experiences of four key groups ideally placed to inform this research. All participants were from a BME background, and efforts were made to ensure that the ethnic and gender make-up reflected that of the two boroughs.

The sample was randomly selected, on a quota basis, until each of the quotas for the groups was fulfilled. The groups were:

- Group 1 - patients who have no need of interpreting and who have been registered with a GP for a minimum of one year.
- Group 2 - patients who are non-English speaking, and who have recently registered with a GP in the two boroughs.
- Group 3 - patients who have used interpreting services regularly in GP consultations over the past 12 months.
- Group 4 - patients who have not been able to register with a GP.

The aim was for each borough to provide 28 participants, with seven in each category.

Two local BME groups, Migrant Resource Centre (MRC) and Umoja Pamoja, were successfully commissioned by the Forum to recruit patients for the project and co-ordinate interviews with them. By commissioning local groups, the Forum aimed to develop:

- Better understanding of and support for Community Engagement in commissioning healthcare services in KCW.
- A stronger role for BME community groups in the new commissioning structure in general and the forthcoming Joint Strategic Needs Assessment in particular.
- Stronger links and partnership work between the BME Health Forum and BME community groups in KCW.

All patients were identified and contacted by MRC and Umoja Pamoja. There were difficulties fulfilling the quota for group four of the patient sample (those who have had difficulties registering with a GP practice). However, the final numbers were deemed sufficient to give information on the issues involved in this research.

The focus group was made up of representatives from local organisations (voluntary and statutory). These were chosen because of the insight that they have through their experiences of working in the field, and close contact with many different BME community groups. The focus group was conducted after the questionnaires were collected, but before the analysis of the questionnaires was conducted. This was not ideal timing as it would have been beneficial to use the focus group to explore some of the findings; but time constraints necessitated this approach.

Analysis

The analysis was conducted by the author of this report, a freelance independent researcher. Each set of questionnaires was analysed and written up in the results section. The patient questionnaire was analysed as a whole sample, but also separately for each of the groups. However, most of the questions did not apply to the fourth group so they have been omitted from much of the discussion.

For reasons of space and focus, the results of each stakeholder analysis are presented in the Appendix. The reader can use these to check any factual detail. These results from the separate stakeholder questionnaires were then reviewed and collated to form the discussion section of the report. This analysis is formed into three sections that are directly drawn from the original objectives of the report. These are: registering and making appointments with a GP; accessing and the quality of interpreting services; the nature and quality of the interpersonal relationship of the GP and patient.

The discussion section has considered the different responses and contradictions, and any related issues. A picture of the situation is outlined, with a focus on opportunities for interventions to make improvements. The results are explored in the discussion in order to ensure that results from one particular stakeholder group are not read in isolation from the others.

Throughout the analysis it was useful to distinguish between the differing trends and experiences of the different sample groups (listed above). The analysis was stratified by the groups, and any stark differences were commented on. Discussions with the Steering Group outlined a need to separate the findings from members of BME communities who have been in the UK for a long time and have adapted to the host culture, and those more recently arrived who may be more linguistically, culturally and socially reflective of their country of origin. Due to their use of interpreting services, sample groups two and three were used as a proxy for this more recently arrived group who are less fluent in English.

Recommendations

The recommendations are the result of discussions on the findings of the report from the BME Health Forum and the independent researcher and they target each of our stakeholder groups:

- Commissioners of health services – PCTs and CEC/PEC
- Providers of health services – GP practices
- Community groups and the BME Health Forum - as strategic level BME patient representatives

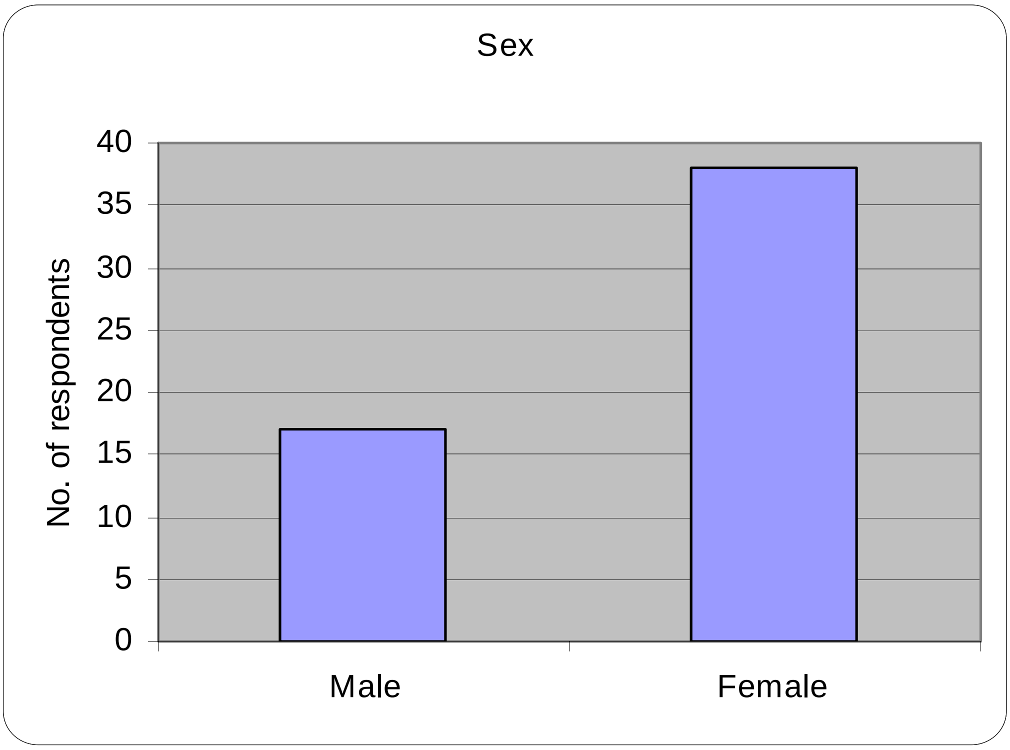
Section 4: Overview of respondents

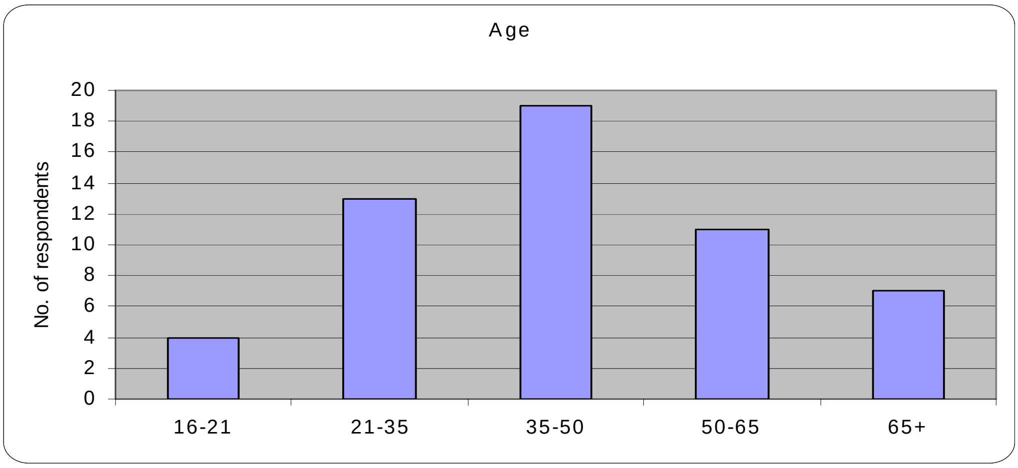
In total 55 people were interviewed, the participants were categorised into four groups:

	Description of the group	No. of participants
Group 1	Patients with no need for interpreting	28
Group 2	Non-English speaking patients who have recently registered with a GP	13
Group 3	Patients who have used interpreting services regularly	8
Group 4	People who have tried but have not been able to register with a GP	6*

** three participants from Group 4 were interviewed using a different questionnaire to the other patients.*

The graph below shows that two thirds of the participants were women. There was also a good distribution of ages.





All participants had used their GP surgery in the 12 months prior to being interviewed, with many of them using it over 7 times. This indicates that the sample has some high users in it.

The ethnic mix and residency status of the sample is presented in the tables below. It shows that there is a good mix of ethnicities, with Black African being dominant, reflecting the local population profile. The Resident/Citizen status shows that most are British citizens, although there is also a good range of people with other status.

Ethnic Group	Number of participants
Other White	6
White & Black Caribbean	1
White & Black African	2
Pakistani	3
Bangladeshi	5
Black Caribbean	1
Black African	18
Chinese	3
Latin American	4
North African	4
Arab	4

Resident / Citizen status	Number of participants
British	24
Asylum seeker	7
European	4
Refugee	4
Indefinite leave	3
Permanent resident	3
Temporary resident*	3
Student	1
N/A or not stated	1

*these were mostly partners of staff working in diplomatic services

Section 5: Discussion

5.1 Registering and making appointments

The patient responses show that patients' experience some difficulties in seeing the doctor of their choice and in getting appointments in general. These difficulties were experienced by all groups but more so by the non-fluent English speakers and/or newly arrived (i.e. groups 2 and 3). There were no problems when requesting specific male or female doctors.

The fact that the practices could fulfil requests to see male or female doctors suggests a willingness to meet patients' requests when possible. The experience of all patients having problems getting an appointment might indicate a general capacity issue rather than an issue specific to patients from BME communities. However, the fact that non-fluent English speakers were more likely to experience problems in getting an appointment, indicates that non-fluency is acting as a barrier. Most of the problems were due to waiting times for an appointment and practices being too busy.

The Focus Group raised the possibility that because of their experience of different health systems and other cultural factors, BME communities have higher expectations of health systems.. Some responses from GPs and practice managers also alluded to this idea. It may be that higher expectations of health services within the BME communities, particularly the newly arrived, lead patients to interpret the wait for a GP appointment as unacceptable.

Alternatively, it is possible that non-fluency in English creates particular difficulties in getting appointments because patients cannot communicate efficiently with practice staff.

Regardless of the cause, there is a clear issue of real or perceived limited access to GP appointments that must be addressed.

Similar conclusions can be drawn from the difficulties experienced in making same-day appointments. Most of the participants found it difficult to make these appointments, especially the non-fluent English speakers and/or newly arrived. The focus group suggested that some practice staff have the pre-conceptions that BME patients are less likely to self-medicate or monitor problems before seeking healthcare and therefore use health service inappropriately. If practice staff do have such preconceptions, it is important that they do not influence the likelihood of giving same day appointments to patients.

Turning to the issue of registering with a GP, most of the patient responses reflected positive experiences, although a substantial number of patients had been asked for documentation whilst registering. Most patients were asked for documents relating to home address while some were also asked for their passports. If these requests are being made only on the basis of race or accent, this is discriminatory. It is unclear on what basis such documentation was requested and for what purpose; and whether similar requests are made of non-BME patients.

Most practice managers and GPs commented that they would register all groups, though most also requested documentation of eligibility. It is not clear whether all newly registering patients are asked to provide this.

The practice staff suggested that they have not received much information from the PCTs to assist in the registration process. The clear uncertainties and inconsistencies in accessing appointments and registering suggest that more information should be made available and actively promoted.

This is underlined by the variation in experiences and responses from the group who could not register with a GP. It should be remembered when reviewing the results that the sample quota was not fulfilled for people who had difficulty registering with a GP. This may influence the findings by not sufficiently representing the views of this group. There may be additional barriers or negative experiences around registering that are not covered in this research. However, some comments help to build a picture of the experiences of this group.

Despite most of this group being asylum seekers, it is difficult to ascertain whether they were refused on account of their immigration status. Often respondents were told that practices are full. It would be useful to find out whether non-BME patients were also turned away from these practices. Whether this exclusion is due to immigration status or due to the practices being at capacity the situation still needs to be addressed. Some of the respondents felt that they could not register because of their status as an asylum seeker:

“I have no status and cannot receive any benefits or help, so I live on the streets and my health gets worse”

“[when trying to register for a GP surgery] they told me I could only register as an emergency patient, or that the list was full. I then got information from the refugee council which helped me”

The latter quote highlights the difficulties in registering with a GP practice, it also shows that people who cannot register with a GP are just being turned away and may not be given information on opportunities to register with other practices. Nor are they being referred to the PCT PALS department who may be able to help them.

There are also variations in efforts to assist patients from BME backgrounds in registering. Some practices have monitored experiences and some provide information on registering in different languages. It would be useful to know if the resources developed by one practice could be easily transferred across to other practices, thereby making the registration process consistent.

All the stakeholders with influence over the management processes suggest that improving access was high on the agenda. However, the PBC clusters felt that it was mostly the role of the PCTs to make improvements in this area. The quality surveys (such as GPAQ and specific practice surveys) in each practice also investigated this issue of access, but the emphasis was on access in general, rather than access specifically for patients from BME communities.

Work can be done to ensure that efforts to address general access issues consider the specific needs of patients from BME backgrounds. Such work may be: flagging up areas or practices of concern to the CEC/PEC; providing information on how practices can engage with the BME communities to assess need; ensuring that BME access is on the agenda; overcoming any difficulties that service improvement efforts have in ensuring access is improved for BME patients. At the moment there are significant gaps in monitoring issues that specifically relate to BME patients – for example, the GPAQ assessment does not address the quality of interpreting services.

Summary of registering and making appointments

The survey finds BME patients express general satisfaction with registering and making appointments. However, there is a substantial minority who are very dissatisfied. These patients are usually non-fluent in English and/or recently arrived. This finding suggests that some practices are not responding to the differing patient needs within their client group. Variation across practices in appointment-making and registration systems and processes suggest there is room for improvement.

In order to provide an equitable service, practices need to become more aware and flexible in responding to different patient needs. However, such change is the responsibility of all stakeholders, and practices need to be supported and empowered in order to achieve this goal. Community groups and BME Health Forum also need to use their knowledge and links to assist in finding solutions and informing needs. The PCT should facilitate this by commissioning activities and using appropriate regulatory or contractual levers.

Recommendations for registering and making appointments:

- The PCTs should provide guidance for practices on entitlements, requirements and documentation.
- Practices should ensure fair and transparent processes in registrations by putting in place procedures which are based on this guidance.
- The PCTs should work with the BME Health Forum to produce fact-sheets for communities (including PALS as a route to raise concerns).
- The PCTs should introduce a system requiring reporting and referring anyone who has been refused registration to PALS.
- The BME Health Forum should identify good practice and roll out by working with a limited number of ‘model’ practices at a time.
- Community groups should actively collect information on practices that are not

fulfilling their obligations in registering patients, and feed into the PCTs.

- Practices should be aware that they can get support and expertise from the PCTs in their efforts to engage with their patients and local community groups to shape services to be more patient friendly.

5.2 Interpreting services

Westminster and Kensington and Chelsea commission different providers for their interpreting service. It is difficult to pinpoint any real differences within the results between the two providers. Therefore the results shown here apply equally to both providers.

The results on the interpreting services section of the patient questionnaire need some caution as the inconsistent use of the term 'interpreter' means that some comments might be referring to family and friends used as interpreters rather than official interpreters provided by the practice. Further caution should be applied to the comments from practice managers and GPs. The nature of them being willing to take part in this study suggests that they may be more attuned and sympathetic to the issues discussed here.

From a provider perspective there was general satisfaction with the quality and provision of interpreting. Interpreting services were regarded to be widely available and offered to those who need it. This contrasts with the view from the patients who suggest that it is not widely available, or at least having to wait for interpreting services limits the accessibility of appointments. There were also some comments regarding the punctuality and availability of interpreters. These seem quite simple issues that should be easily addressed with appropriate negotiating between the commissioners and providers of interpreting services. The cost implications of missed or extended appointments as a result of this provide a strong business case for the providers to address this.

Also there is a stark difference of opinion within the patient group. There is a satisfied group of patients accessing and using official services and a very dissatisfied group of patients who lack access and confidence in interpreting services. The latter patients who sometimes use friends and family as interpreters face other problems such as long waits when family and friends are not available, lack of privacy, and risks to the accuracy of the consultation. As illustrated by one respondent:

“I have never needed an interpreter at the surgery as I always have my own. But I have to wait until my friend or my son is available [to come with me and act as an interpreter]”

The issue of patients bringing their children to interpret needs to be addressed as a matter of urgency. This presents a clinical risk that should prompt medical staff to take action. Patients who use unofficial interpreters should be discouraged from doing so in future and flagged on the system to ensure an interpreter is booked when they make an appointment. Practices must refuse to treat patients who bring their children to interpret for them, except in emergencies.

This contrast of satisfaction and uptake in the patient sample indicates that there is variation in access and quality of services. Some practices have demonstrated effective implementation in delivering interpreting services and the rest of the practices need to be brought up to a similar standard. Although, the interpreters in each borough are employed from the same central company (different companies supply each borough), the evidence suggests that the quality of interpreting also varies from interpreter to interpreter.

“I use an interpreter every time; there is always one at the surgery”

But some practices do seem to have some protocols in place, yet these do not seem to always be working – as this quote highlights:

“I was asked to fill in a form requesting Arabic interpreting, but I was never provided with one and told to bring my own with me at the next appointment”

Whether these issues of having limited access to good quality interpreting services are real or perceived is unclear. Interpreters are employed in a central company (though separate companies provide services for each borough) which provides for all practices suggesting that there are differences between practices in terms of promotion and processes. Alternatively, it may be that differences in patient perceptions or expectations also need to be considered and managed.

The provision of in-site interpreting service is particularly relevant in the light of Lord Darzi’s Healthcare for London proposals in which polyclinics are being promoted as the future of the NHS with plans to have 150 built across England. These multi-purpose super GP clinics will be able to offer a far greater range of services than currently offered in GP practices, whilst being more accessible and less medicalised than hospitals. This, however, could have a negative impact on patient-doctor relationship as it can make it harder for patients to see the same doctor. This may unfairly prejudice against non-English speakers who have specifically chosen the register with a doctor with specific language skills. The solution is on-site interpreting services.

The second issue is around the patients' use of friends or family as their interpreter. As some of these patients had previously used interpreting services it suggests that using friends and family may not be their original preference and may be a consequence of losing confidence or access to interpreters.

It may be that there will always be some patients who will have a preference for friends and family, due to a perceived lack of suitable alternatives, and/or concerns about confidentiality and inconvenience. The following quote illustrates this choice being due to poor quality official interpreting services.

“I used to have problems [with official] *interpreters but since I decided to bring my own I feel fine”*

However, the use of friends and family as interpreters should be discouraged. Poor unofficial interpreting can pose a threat to patient safety and GPs and other health practitioners need to consider their clinical responsibility for the consequences of any misunderstandings or miscommunication in their consultations. Community groups should also be provided with leaflets and training, to ensure that if patients do turn to friends or family they are aware of the risks.

Indications from the CEC/PEC and the PBC Clusters showed that there were no great concerns over the interpreting service. It was also noted by the PBC Clusters that the role for improving the interpreting services would lie with the PCTs. It seems therefore likely that concerns over the quality and consistency of interpreting services need to be shared with the commissioners before action is taken to address the situation.

Lack of confidence and lack of access to the official interpreting services may be affecting uptake of these services and therefore affecting access to healthcare. This should be shared with commissioners to build a case for reviewing the service and informing commissioning of interpreter services in future health service provision.

However, a more systematic and objective assessment of the quality of the interpreting services is needed. Incorporating their assessment into the GPAQ is one option, but this needs careful consideration because the number of respondents to that survey who use interpreting services is uncertain.

Provision of interpreting and integration

One reason for concern about the use of interpreting services is the public perception that interpreting and translation services impede the integration of immigrants to mainstream British society. For example, the former Communities Secretary Ruth Kelly stated in various interviews in 2006 and 2007 that she believes that translation services are used too frequently by public services. Nevertheless, she acknowledged that Accident and Emergency was one area in which interpreting and translation services were essential. Similarly, ‘Our Shared Future’, the final report of the Commission on Integration and Cohesion, which was published in June 2007, was critical of the use of translation services in certain instances but it also stated:

“We recognise that language barriers can perpetuate inequalities. Taking health services as an example, if people don’t know how to access services, they may not get the care they need. Even if they get to the right doctor, without good English they might not get the right diagnosis – or understand it – and may not take the treatments prescribed. There are clearly vulnerable groups who need particular support.” (Our Shared Future, 2007, p. 167).

While stakeholders may have a variety of personal views on the benefits of public services using interpreters and translating material, with regard to medical services in particular, it is clear that doctors have a clinical duty to ensure that their patients have understood fully the information they have been given and commissioners have the legal duty to ensure patients who are not fluent in English receive equally good health care as all other patients. These duties are not negotiable and will remain independently of other developments to support migrants to learn English and integrate more successfully in UK society.

Summary of interpreting issues

There is a stark difference between providers and patients in their satisfaction and assessment of interpreting services. Some patients who regularly use the official interpreters are satisfied. Interestingly these patients are also more likely to have positive relationships with their GPs. We do not know why some patients ask family and friends to interpret for them instead of using official interpreters. Possible explanations are that they have used official interpreters in the past and found the service unsatisfactory, that they are unaware of the interpreting service, or that they are not given the opportunity to use the service. An objective evaluation of the interpreting services and the reasons why patients seek other alternatives is needed.

The systems used to provide interpreting services vary across practices, which means that there is opportunity to identify and share good practice. The use of unofficial interpreters has implications for patient safety and clinical governance. As overall commissioners of these services, the PCTs should take the lead in ensuring evaluation is undertaken. As providers of healthcare, GP practices should work to ensure that the interpreting services are meeting the varying needs of the patients both in terms of language and systems. Community groups and the BME Health Forum have a responsibility to ensure that feedback to them is being channelled through the established patient complaints procedures so it can be acted upon accordingly.

While stakeholders may have a variety of personal views on the benefits of public services using interpreters and translating material, with regard to medical services in particular, it is clear that doctors have a clinical duty to ensure that their patients have understood fully the information they have been given. commissioners have the legal duty to ensure patients who are not fluent in English receive equally good health care as all other patients.

Recommendations for interpreting:

- Practices should seek the feedback of their patients on interpreting services.
- The BME Health Forum should work with practices to identify and develop good practice in relation to providing interpreting support.
- The PCTs should produce/reissue guidance and arrange training for Practice staff on working with interpreters.
- Practice should consider fluency in a community language as a desirable criterion when recruiting practice staff.
- The PCTs should have the provision of interpreting services as a key requirement in all future commissioned services.
- BME Health Forum and community groups should actively promote the availability of interpreting services to their members.
- BME Health Forum and community groups should encourage patients to report dissatisfaction with service, either through a system in the community sector or through PALS.
- The issue of patients bringing their children to interpret needs to be addressed as a matter of urgency. Practices must refuse to treat patients who bring their children to interpret for them, except in emergencies.
- The PCTs should explore the potential for using the Quality Outcomes Framework in providing incentives to GPs to assess their patient language needs.
- The PCTs and practices should investigate the potential for innovative non-verbal communication techniques - such as using pictures during consultations where an interpreter has not been booked or does not turn up.
- The BME Health Forum must develop a guide to interpreting for family and friends
- Community groups must actively promote the information on interpreting for family and friends.
- There may be developments in PBC Clusters commissioning that put the procurement of interpreting services within the remit of Clusters. Options around improving access, uptake, and quality of interpreting services should be explored in preparation.
- The PCTs and practices need to review or develop protocol for cases where

unofficial interpreters are used. There is a clear issue of patient safety here that falls under the responsibility of the doctor.

- The PCTs should lead a full joint review, in partnership with all other stakeholders, to revise/establish standards for interpreting support across KCW.
- When developing polyclinics, the PCTs must ensure that these facilities are supported with in-site interpreting services.

5.3 Relationship between GPs and patients

The patient responses showed that there was no overwhelming sense of dissatisfaction with the doctor/patient relationship. Indeed, there are high levels of trust and patients feel respected, particularly those who are newly arrived. The quote below illustrates this general satisfaction, and the role that **all** staff in general practices have in ensuring a satisfactory patient/doctor relationship.

“from the receptionist to the doctor they all respect me”

Nevertheless, some patients experienced low levels of trust and did not feel respected. This suggests that, whilst general satisfaction is apparent in most patients, there are some who are deeply dissatisfied. The data do not allow us to identify any shared characteristics of this dissatisfied group, so reasons for this are unclear. What is clear is that in health services having a dissatisfied group of that size (around 10 people from the sample of 49 able to answer), is unacceptable.

Generally speaking there was also some dissatisfaction in areas where interpersonal skills are required. In some cases the responses indicated that some very negative experiences had occurred and patients were extremely upset about them. Some of the negative perceptions of the patient/doctor interaction were due to the attitude or communication style of the doctor, whilst others were more related more to the lack of time given to the patient as the following quotes illustrate:

“my GP is very efficient but does not show much sympathy as he is very business like; and when he hurries I do not feel respected”

“they have limited time and so sometime no care is really taken”

The focus group discussions suggested that the patients’ backgrounds might influence their interaction and utilisation of the health services. For example, the experience of other health systems as well as other socio-cultural characteristics of certain BME communities may inhibit their ability to get the most from the health services. Furthermore, the perceptions of healthcare staff and the particular workings and culture of the UK health system may interact with certain characteristics of the BME communities to produce negative relations.

The focus group suggested that doctors are more likely to be esteemed and held in high respect by BME communities; this is reflected in the high levels of trust shown in the patient questionnaire. These feelings, however, correspond to high expectations of UK healthcare availability and services. Furthermore, BME patients who are unfamiliar with free, socialised medicine may be not familiar with the expectation for the patient to self-medicate where appropriate and that referrals are made exclusively on the basis of clinical necessity. Finally, the communication style of people for whom English is not their first language is less concise which can conflict with doctors conducting clinical diagnoses within a time pressured health service.

The existence of some of these perceptions was confirmed to an extent by comments from the interviews with health professionals and managers. It seems that this situation creates a vicious circle where ineffective consultations are brought about by a lack of full engagement from both parties. Because patients feel they were not treated appropriately, they feel they need to revisit which then leads to a worsening of attitudes from the healthcare staff.

There is a danger that these issues are not being fully recognised. Practice managers and GPs suggested that their communication with BME patients was satisfactory. However, there was a feeling from these respondents that there is room for improvement in this area.

It might be concluded, from this research, that practice staff see the BME communities as being more demanding and less engaged. This is accompanied by a perception that since poor relationships or communication are the result of particular BME characteristics, the solutions must lie within the BME communities also.

On the other hand, the results overall reflected that BME patients are satisfied with the way that they are treated. It is only in issues dictated by the healthcare system that there was considerable dissatisfaction (such as time spent with patients, etc). This indicates that a better understanding of the system, and its inherent problems, may improve the perceptions BME communities have of their own interactions with healthcare staff.

Therefore the solutions should arise from both groups. Patients would benefit from a better understanding of the system and the cultures within it. Staff should recognise that an approach of treating all patients the same is not catering for the differing characteristics of patients.

However, doctors and patients do not have equal influence in being able to shape services and relationships. Although both can influence the nature and quality of future services and relations, the doctors’ role as professionals puts the onus on them to improve matters.

Patient groups working with the BME communities can also make efforts to help patients understand how their own behaviours may put them at a disadvantage. Recognising that in the limited time frame of the consultation, poor communication may affect negatively the doctor’s understanding of symptoms, may give greater incentive to patients to seek official interpreter services.

The focus groups suggested comprehensive training for all healthcare staff in understanding the background of the communication problems, and knowing how to deal with them. However, it is uncertain whether such training would be taken up by those who would most benefit. Training is already available in some practices, however, it is not specific to BME issues and opportunities to feed in to this should be explored.

Both PCTs have access high on the agenda, and work is ongoing to improve access to services. It is important to ensure that work in this area considers attitudes and relationships as having an influence on access.

Summary of issues in GP and patient relationships

The majority of respondents were satisfied with their relationship with the GP or practice staff. However, again, a large number of patients were very dissatisfied, and this may influence their uptake and confidence in the system. Cultural and language factors within particular subsets of the patient group are clashing with the capacity and pressures of those working in the healthcare environment. The combination of these perspectives has resulted in a breakdown of trust for some patients, and a very dissatisfied patient subgroup. Poor relations between patients and providers, regardless of cause or responsibility, are likely to lead to increased visits and costs. Poor relations lead to revisits, prompted by lack of confidence in diagnosis, and in patients presenting later and therefore needing more care. It is therefore in everyone's interest to improve relations with all patients.

The presence of poor relations or lack of confidence is not recognised by all GPs and practice managers, while some who do recognise it have placed the responsibility for the situation on the behaviours of BME patients themselves. However, the providers have the responsibility of ensuring equity through appropriateness of care, and therefore need to assess the behaviours they find challenging and act to ensure that their service is responsive to the particular needs of the patients. The issue of training has been raised, but the real aim should be improving customer care - training may or may not be the best way of achieving that. Despite the responsibilities of the providers, in a publicly funded system there is also a role for patients to ensure effective use of the resources. The BME community groups should play a role in promoting responsible use of services.

Recommendations in enhancing patient-GP relationships are:

- The PCTs should review/develop training programme for practice staff to ensure that Knowledge & Skills Framework (KSF) competencies for Equality & Diversity are effectively integrated.
- Practices should monitor their patient lists and take steps to ensure that their patient groups/panels reflect the diversity of their patient population.
- Practices should use patient groups/panels, local community groups and the BME Health Forum as a route for improving their understanding of local communities and communities' understanding of NHS services and practices.
- The PCTs should require practices to undertake patient profiling.

- The BME Health Forum should work with practices to identify and develop good practice.
- The PCTs, the BME Health Forum and the PBC Clusters should jointly produce fact-sheets for community groups on NHS Primary Care and how it works.
- Community groups and the BME Health Forum should actively disseminate and distribute these fact-sheets.
- The BME community groups should develop and seek funding for community-based projects for improving access to primary care services for their communities.
- The PCTs, Local Authorities and NHS providers should commission and support. community-based projects which address the issue of access to primary care services.

5.4 Discussion summary

Some key themes can be picked out from the analysis and discussion of the results. Firstly it is an extremely complex area that will benefit from the efforts of numerous stakeholders. Although there are no overwhelming feelings of dissatisfaction across the patient group, there is a substantial minority of patients who are experiencing limited access and low satisfaction with their GP practice.

Inconsistencies in registration processes for patients from BME communities should be addressed; with a focus on ensuring access to all, regardless of their immigration status or language abilities. There also needs to be an understanding of the time pressures at practices and the availability of GP appointments. Procedures in this should be fairly consistent so there is potential for good practice in particular GP practices to be identified and rolled out.

There are concerns over the quality of interpreting services; efforts should be made to establish how to improve this. The PCTs should review their interpreting services to revise/establish standards for interpreting support across KCW. In the short term, the BME Health Forum and community groups should actively promote the availability of interpreting services to their members and discourage them from using unofficial interpreters. Most importantly, GP practices can look at how they can play their part by developing systems in booking interpreters, establishing and feeding back the interpreting needs of their patients, and dealing with unofficial interpreters (both at the time and in anticipation of them being used again in the future).

Relations between the provider and the patient need to be improved, although it is likely that this will take a long time. In the short term, GPs and practice staff can be informed of some of the reasons for differences in communication or engaging. Improving the customer care of their service is more likely to result in a more responsive and flexible service.

A lot of promotional work can be done in the community, addressing patients' perceptions and informing them of service availability and good practice. Across the health services there seems to be much that can be done centrally.

The issue of improving access in general seems to be on everyone's agenda. There are also indications that improving access for patients from BME communities is on the agenda too. However, addressing BME access issues must take into account the following issues:

- Whose obligation it is to address it
- How it can be addressed, and
- Who will do the work to address it

The focus of the recommendations reflects these concerns found in the stakeholder groups.

Work and support can be delivered centrally, from groups who prioritise BME access issues, such as the PCTs, the BME Health Forum and certain community groups. They can identify good practice, disseminate information, and inform of areas of concern in addressing barriers specific to BME groups. This process will then make it easier for PCTs and practices to take action on improving access for BME groups.

5.5 Ways forward – policy and influence

The policy mechanisms available can only work when given information to act on. For example, responses from the focus group suggested that there may be numerous incidences that require attention from the PCTs. Patients reported that during those incidents they obtained assistance from community groups. However, it was not clear if reports were ever fed back to the PCTs to act upon and ensure improved services. Practice managers and GPs seemed to be satisfied with their staff, and CEC/PEC Chairs and PBC Chairs were satisfied with the quality and consistency of service. This was partly because they believed that if there were areas of concern, they would already known to them.

Community groups and the BME Health Forum need to work to ensure that the feedback loop to improve services is put to use. Practices are then, more likely, to act on the feedback. Patient experiences and views must be used to shape services.

The current role of Practice Based Commissioning Clusters is focused on the commissioning of secondary services. In this context they can work to improve the accessibility of those services, but they have no role in commissioning other GP services.

Although the Clusters do not have any contractual levers with their members, they do have influence via established communication mechanisms and meetings. These arrangements might help to facilitate the roll out of good practice in future. They also have the potential to reduce costs of future interventions through economies of scale. Regardless of commissioning or governance remit, any opportunity to influence quality of services should be taken. For example, a PBC Clusters that employs a links worker will be improving the patient input into developing all of their services at a fairly low cost.

The BME Health Forum is in a position where its agenda is accepted by stakeholders, and most stakeholders agree that there is an issue that needs to be addressed. The Forum can also use its contacts in the community and the health service to develop good practice, which can be assessed, evaluated and rolled out.

Finally, community groups can play a role in shaping the understanding of patients from BME communities. By advising on what to expect from the health service, and tempering expectations, they can reduce the patients’ anxieties and feelings of being let down or badly treated. They can also act on reports of bad practice through PALS or their own developed systems. Undertaking these exercises jointly with the PCTs or with practices can ensure that these actions have a tangible effect on service.

Any activities undertaken by the BME Health Forum should be appropriately directed and commissioned by the PCTs. However, the commissioning of these services should be done in a way that ensures high quality outputs and returns. Joint working with the PCTs, training to build capacity, or funding for input of external expertise, should be considered to secure these high quality outputs and returns.

Section 6: Summary of recommendations by each stakeholder group

Providers

Recommendations for registering and making appointments:

- Practices should ensure fair and transparent processes in registrations by putting in place procedures which are based on the PCTs' guidance.
- Practices should be aware that they can get support and expertise from the PCTs in their efforts to engage with their patients and local community groups to shape services to be more patient friendly.

Recommendations for interpreting:

- Practices should seek the feedback of their patients on interpreting services.
- Practice should consider fluency in a community language as a desirable criterion when recruiting practice staff.
- The issue of patients bringing their children to interpret needs to be addressed as a matter of urgency. Practices must refuse to treat patients who bring their children to interpret for them, except in emergencies.
- The PCTs and practices should investigate the potential for innovative non-verbal communication techniques - such as using pictures during consultations where an interpreter has not been booked or does not turn up.
- PCTs and practices need to review or develop protocol for cases where unofficial interpreters are used. Considering refusal to treat or flagging up interpreting services. There is a clear issue of patient safety here that falls under the responsibility of the doctor.

Recommendations in enhancing patient-GP relationships are:

- Practices should monitor their patient lists and take steps to ensure that their patient groups/panels reflect the diversity of their patient population.
- Practices should use patient groups/panels, local community groups and the BME Health Forum as a route for improving their understanding of local communities and communities' understanding of NHS services and practices.

Commissioners

Recommendations for registering and making appointments:

- The PCTs should provide guidance for practices on entitlements, requirements and documentations.
- The PCTs should work with the BME Health Forum to produce fact-sheets for communities (including PALS as a route to raise concerns).
- The PCTs to introduce a system requiring reporting and referring anyone who has been refused registration to PALS.

Recommendations for interpreting:

- The PCTs should produce/reissue guidance and arrange training for Practice staff on working with interpreters.
- The PCTs should have the provision of interpreting services as a key requirement in all future commissioned services.
- The PCTs should explore the potential for using the Quality Outcomes Framework in providing incentives to GPs to assess their patient language needs.
- The PCTs and practices should investigate the potential for innovative non-verbal communication techniques - such as using pictures during consultations where an interpreter has not been booked or does not turn up.
- PCTs and practices need to review or develop protocol for cases where unofficial interpreters are used. Considering refusal to treat or flagging up interpreting services. There is a clear issue of patient safety here that falls under the responsibility of the doctor.
- The PCTs should lead a full joint review, in partnership with all other stakeholders, to revise/establish standards for interpreting support across KCW.
- When developing polyclinics, the PCTs must ensure that these facilities are supported with in-site interpreting services.
- There may be developments in PBC Clusters commissioning that put the procurement of interpreting services within the remit of Clusters. Options around improving access, uptake, and quality of interpreting services should be explored in preparation.

Recommendations in enhancing patient-GP relationships are:

- The PCTs should review/develop training programme for practice staff to ensure that Knowledge & Skills Framework (KSF) competencies for Equality & Diversity are effectively integrated.
- The PCTs should require practices to undertake patient profiling.
- PCTs, BME Health Forum and PBC Clusters should jointly produce fact-sheets for community groups on NHS Primary Care and how it works.
- PCTs, Local Authorities and NHS providers to commission and support community-based projects which address the issue of access to primary care services.

Community groups and BME Health Forum

Recommendations for registering and making appointments:

- The BME Health Forum should identify good practice and roll out by working with a limited number of 'model' practices at a time.
- Community groups should actively collect information on practices that are not fulfilling their obligations in registering patients, and feed into the PCTs.

Recommendations for interpreting:

- The BME Health Forum should work with practices to identify and develop good practice in relation to providing interpreting support.
- BME Health Forum and community groups should actively promote the availability of interpreting services to their members.
- BME Health Forum and community groups to encourage patients to report dissatisfaction with service, either through a system in the community sector or through PALS.
- The BME Health Forum to develop a guide to interpreting for family and friends
- Community groups to actively promote the information on interpreting for family and friends.

Recommendations in enhancing patient-GP relationships are:

- The BME Health Forum should work with practices to identify and develop good practice.

- PCTs, BME Health Forum and PBC Clusters should jointly produce fact-sheets for community groups on NHS Primary Care and how it works.
- Community groups and the BME Health Forum should actively disseminate and distribute these fact-sheets.
- BME community groups to develop and seek funding for community-based projects for improving access to primary care services for their communities.

Appendix 1 Results

The results section is informed by the five questionnaire samples, a focus group session, and a short review of relevant literature. These will be analysed separately and will be presented in the following sections.

A1	Patients
A2	GPs
A3	Practice managers
A4	Cluster leads
A5	CEC/PEC
A6	Focus group of BME Health Forum members and key community representatives

A1 Results – Patients

A1.1 Accessing GPs

This section on patients' experiences and perspectives in accessing the GP is informed by two sections of the questionnaire:

Getting to see a GP in your practice (question 2)
Same day appointments for urgent cases (question 4)

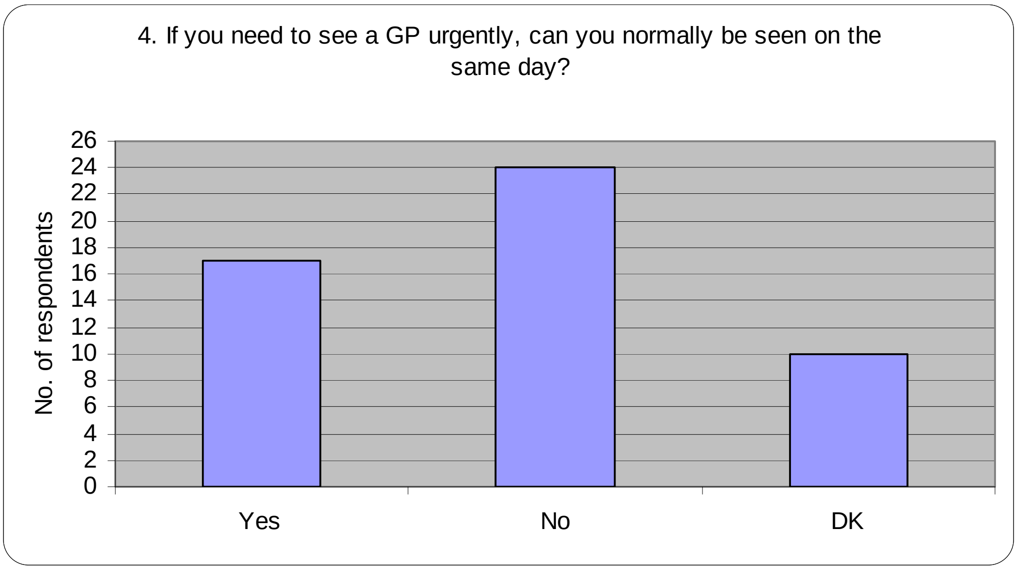
Overall around half of the respondents had had some difficulties in getting an appointment with a GP. Those in groups 2 and 3 of our sample were more likely to find it difficult to get an appointment with the GP. Reasons given for this were all around the issue of waiting times and practices being too busy. There was no indication of how long people had been waiting, or how long they see as an acceptable time to wait for an appointment. None of the difficulties related to actually accessing a GP service, rather it was accessing GP appointments. However, this does not indicate universal good access. Because the sample consists mainly of people who have used GP services the views of those with limited access are not fully represented here. It is not appropriate to comment on whether the sample misses these 'limited/no access' groups out because they are few in number, or because the sampling methodology was not appropriately designed to engage with them.

Turning to the question of seeing the GP of choice, most respondents had no problems in this. Interestingly it was again groups 2 and 3 from our sample who were more likely to have negative experiences.

Most respondents had not had any need to request a specific male or female GP, and were happy with their GP. Those that had asked were unlikely to have encountered difficulties in their request. The few problems arising from this were centred on having to wait longer for an appointment.

Most of the general problems in accessing their GP were around unavailability. Respondents had negative experiences when their GPs were on holiday, or they were forced to see other GPs instead (often temporary cover GPs). A few respondents said it took them around 3 weeks to get an appointment with their GP. Again the respondents from groups 2 and 3 were more likely to experience problems

The graph below shows that most respondents have found it difficult to see a GP in the same day, even in urgent cases. Respondents from groups 2 and 3 were much more likely to say that they have not been able to make same-day urgent appointments.



A1.2 Relationships with GPs

This section on patients' experiences and perspectives of their relationship with the GP was informed by three sections of the questionnaire:

- Relationship with the GPs in your practice (question 3)
- Communication and quality of the consultation (question 5)
- Rating of receptionists and other staff at the practice (question 10)

Four fifths of the participants showed high levels of trust when asked about their trust in the GPs in their practice. Interestingly, those who had the most trust were those participants from group 3. Those that showed distrust in their GP did so because they felt that they were not being given enough time or attention, or that they were being prescribed pain killers for all conditions.

When asked whether they felt respected by the GPs in their practice the respondents were even more positive. A third of the participants from group two felt there was not enough respect. All but one of the participants of group 1 and group 3 felt respected. Those who did not feel respected commented on feeling very upset about their consultation and the lack of respect shown.

Again it was participants from group two who were less likely to have felt positively about their GP when asked whether they feel GPs in their practice are sympathetic to their health problems. Two thirds of that group felt that the GP had not been sympathetic; whereas only one fifth of the other groups felt dissatisfied in the same way. Reasons for this dissatisfaction varied from not having enough time, not ordering further tests, and suggestions that the health problems are a result of the patients' depression.

The patients were also asked to rate their most recent consultation with the GP on issues such as thoroughness of consultation; how well the doctor listened and put them at ease; involving the patient and explaining to them; and the patience and care shown to the patient.

The table in the appendix shows these results for the whole sample, and separately for the three groups of interest. Levels of satisfaction were generally higher on issues such as asking what is wrong with the patient, understanding what the patient is saying, and putting patients at ease during examinations. There was less satisfaction around the issues that are more related to patient involvement in care and patient-doctor relations, such as care and concern shown by the doctor, patience in answering the patient's questions, and the time given to the consultation.

The results show that where there is general dissatisfaction or negative opinions, these are more strongly and more likely to be felt within groups two or three. This is consistent with the themes coming out from the other more qualitative questions. The question areas where there was the biggest differences between the groups were around the amount of time spent, the doctor's patience with questions or worries, how much the doctor listened to the patient, and explaining what was wrong or about the treatment.

The questionnaire asked the patients to comment on the reception staff at the surgery and whether they felt they were friendly, helpful, sympathetic, and whether they respect their confidentiality (answering yes or no on all).

Overall slightly more than three quarters of respondents answered positively about each of these; more people responded with 'not sure' than with a negative response. These proportions held across all three groups. Although groups two and three had slightly lower positive proportions, with just under three quarters being positive

A1.3 GP processes

This section on the procedures around referrals and registrations was informed by two sections of the questionnaire:

- Referral to hospital (question 6)
- Registration with the GP (question 7)

Respondents were asked whether they had been referred to hospital by their GP in the last year, and those who had were then asked about their experiences. Two fifths of respondents had been referred to hospital. Half of group one had been referred, whilst only a quarter of groups two and three had been referred. Of those that had not been referred there were a couple of comments around staff (GPs and reception staff) being rude in denying the patient their requested referral to hospital.

A small number of respondents had experienced problems in getting a referral from their GP to a hospital appointment. This was the same across all groups.

There was a large variation in time taken in getting to see a hospital doctor after being referred. This time ranged from a few days to several months. This variation may reflect the variety of procedures that they were referred for; no data on procedures was collected.

When asked about their opinion on the length of the wait, most of these respondents who had been referred felt that it was too long. Three fifths of all respondents who have had a referral said that it was too long. This dissatisfaction went down to half for group one, but was around three quarters for groups two and three.

When asked about their experiences when registering with a GP around one third of groups two and three had problems. For group one this proportion was only one fifth. It should be remembered that the definitions of groups two and three suggest that they would be more likely to have registered recently, as they are less likely to have been in the UK for as long as group one.

Apart from those who have been specifically selected because of their difficulty in registering with a GP, there were very few respondents who have not been able to register. There were also very few who felt that their immigration status had affected their registration. Another issue of consideration is the difficulty that this research project had in finding respondents who have not been able to register with a GP.

However, three quarters of all respondents have been asked for documents when registering for a GP. This proportion was similar across all three of our groups. The type of documents requested were passport, immigration documents, Home Office papers, medical card, or proof of address. In the majority of cases it was proof of address, occasionally Home Office papers that were asked for as well, and in a couple of instances a passport was requested.

There were six respondents who had been unable to register with a GP; of these four were asylum seekers, one was on spousal visa, the other British of Black African ethnicity. Five of the refusals were due to the practices having full lists, and could not accommodate any more patients. Only one was solely due to the immigration status, and that incident was for a North American resident whose visa had one month left to run. There were also two respondents who said that one of the reasons given for refusal to register was that the practice did not have interpreting services.

However, three respondents felt that it was their immigration status that affected their ability to register with GPs. The remainder accepted that practices were busy, or that their postcode was not within the practice catchment area. All participants from this group were asked to provide documents when they attempted to register. These did not differ from the other groups, in that they ranged from passports, proof of address, and immigration papers.

Worryingly, two of the respondents who could not register had health conditions that potentially needed urgent attention. One was pregnant, the other was getting involved in drugs. There were some responses that suggested that the GP practice is being seen as more than a primary healthcare centre, with patients concerns over housing being raised with healthcare staff. Another comment on difficulties in registering came from a recent arrival in this country. The respondent suggested that people in his situation, newly arrived from a developing country, are expecting a higher standard of health care than that which they are receiving.

A1.4 Interpreting

This section on the patients' opinions and experiences of needing interpreting for their GP consultation was informed by one section of the questionnaire:

- Interpreting at the GP practice

Although the two PCTs use different interpreting services, it was difficult to pick up any differences in satisfaction between the two.

Group 3 of the respondent categories is made up of patients who use interpreting services regularly. Patients from Groups 2 and 4 are also in this section if they used and commented on interpreting services. The fact that these patients are not in group 2 indicates that they do not use the service on a regular basis.

It seems there is confusion about the term ‘interpreter’. Whilst some respondents included anyone who translates for them during a consultation as an interpreter, others referred to only officially provided interpreters. This inconsistent perception of the term should be considered when viewing these results.

Overall, 16 respondents said they have used some form of interpreting. Of these, nine have used official interpreters, and seven have brought their own. Some respondents mentioned that they have used both in the past.

Of those providing their own interpreting they were mostly bringing friends or family. Worryingly, half the respondents bringing their own interpreter have used their children for the interpreting. Some have not felt concerned by this, but others said they have done so reluctantly.

Problems encountered by people providing their own interpreting often relate to the availability of their friends/family to attend. Some cite problems in accessing official interpreters; some patients suggest that they do not get offered any interpreting assistance or that they will not get treated if they do not bring their own. Users of official interpreters occasionally experience delays through the interpreter not turning up. Although, they are less likely to cite problems or delays due to their interpreting needs than their counterparts who use family/friends.

It is unclear whether patients using their own interpreters do so because of personal preference, lack of access to official ones, or convenience of family/friends.

Very few respondents were dissatisfied with the GP consultation using an interpreter. Most feel that they can communicate well with the GP when using their interpreter (official and unofficial). A couple of respondents commented that they do not feel comfortable with the interpreter situation. It wasn’t clear whether this was to do with the quality of interpreting or just having a third party present. Discussing health issues in front of one’s child was mentioned as problematic by one of the respondents who had used their child as an interpreter.

In summary, most respondents have encountered problems with getting the assistance of the interpreter for their consultation, and their need for interpreting has delayed their consultation. However they have been satisfied with the interpreter they have used and could communicate well.

A1.5 Information from the practice

This section on the information available or offered to patients was informed by one section of the questionnaire:

- Advice and information about your health issues
- Advice and information about the practice services

Just under half of all respondents said that their practice provided them with useful advice and information about their health problems, about a third had not been provided with this information. These patterns held over the three different groups. It should also be noted that there were some differences in the understanding of what is meant by 'advice and information' within this question. Some respondents were referring to leaflets and some to actual advice by GPs or other staff. Of those who were talking about written information a couple mentioned the limited use of it due to the language barriers. It is also not clear if the information is handed or given to respondents, or picked up in waiting rooms.

When asked about information about other health services the respondents were even less likely to have received information. Overall, and within the different groups, around three fifths of the respondents had not received any such information. Of those who had, it was most often related to the service that they were being referred to or encouraged to use. There remained the issues relating to the language of the written information.

A2 Results - General Practitioners

Patient groups/panels

Three of the five GPs had patient groups/panels in their surgery. Those with patient groups suggested that the PCTs or BME Health Forum could have a role in increasing the participation and activity of those groups. Practices without groups said that setting up a patients' group would be difficult, and there are considerable time issues involved. Doctors also stressed concern that groups might not be representative.

Practices with patient groups/panels have taken on board recommendations and in most cases acted upon them. Most of the recommendations were around access, either ensuring that patients have access to the same GP for routine care or extending opening hours to improve access. There was no mention in these recommendations of specific BME issues.

Interpreting services

All of the GPs questioned said they ensure that patients have access to interpreting services, although they did say that it was difficult at short notice. Some GPs pointed out that patients brought their own interpreters (i.e. friends or family to interpret for them) and in some cases the GPs themselves could speak the patients' language. There were concerns over the quality of interpreting, with a GP commenting that it is very difficult to have a consultation in this way, especially when the interpreting is poor.

It seems that the GPs are not aware of any formal assessment of the interpreting services. Some GPs were reassured of the quality of the service because patients requested the same interpreter or simply did not complain. All recognised that there were difficulties in assessing the quality of interpreting services. Current ad hoc ways of assessing interpreting services included looking at the availability and punctuality of the service and trying to communicate directly with the patient to ensure that accurate information is being conveyed and the patient is satisfied with it.

None of the GPs were sure that patients had been asked about the quality of interpreting services. However, it should be noted that the GPAQ does not include an assessment of interpreting/language support.

None of practices had received any recommendations to improve their interpreting services from the PCTs. All interpreted this as a form of satisfaction with the current service, suggesting that if there were any issues the PCTs would have made some suggestions about resolving those problems.

Registration

Most practices felt that they had a satisfactory service in registering patients. One had translated their registration form; another had improved staff awareness of BME issues through implementing training on the issue. A further practice had sent out a pamphlet asking for ideas on how to improve services, and providing some information on the issues involved.

Most practice managers and GPs commented that they would register all groups, though most also requested documentation of eligibility. It is not clear whether all newly registering patients are asked to provide this.

Improving consultations for asylum seekers and refugees

All but one of the GPs was willing to meet with patients to help improve services for asylum seekers or refugees. Time was pointed out as a major barrier. One GP argued that there will always be problems with asylum seekers and refugees and that it was better to spend scarce time on more patient consultations. One of the GPs used to have a group which discussed these issues and commented that it was very useful.

Improving communication with BME patients

Most GPs were quite positive about their existing communication with BME patients. Three of the practices would often discuss this during regular general meetings, and suggested that any issues would be solved in that forum. Most of the practices had general communication courses, but they did not think that it was specific to BME groups.

Most of the GPs were confident that the GPAQ demonstrated satisfaction from the patients about the way the staff treat them. However, it should be noted that the GPAQ does not include an assessment of interpreting/language support. One suggested that, despite general satisfaction, there would be room for improvement as the receptionist in their practice was unsure that the patients feel understood.

Improving access through the PBC Clusters

All GPs able to comment on this thought that the PBC cluster would be interested in improving access if a need in this area was found. They felt that they would be happy to adopt PBC recommendations.

Other comments

Two stressed the importance of this project, and were keen to learn of the findings and act on the recommendations. There were general comments about cultural awareness being very important. One GP commented on the importance of communication being a two-way process, with the patients able to teach the GPs about the different perspectives and beliefs of various cultures.

A3 Results – Practice Managers

Registering process and information

Three of the five practices have information available in other languages, although they commented that it was only in a limited number of languages. All practices felt that having information in different languages is an area that could be developed.

Only one practice had monitored the experience of BME patients in registering. None expanded on this issue.

There was a noticeable difference between practices in the number and type of documents patients are required to produce in order to register. Most centred around confirming address and demonstrating eligibility (with a passport or letter from the Home Office).

Most practices treated asylum seekers the same as refugees. They would want from both groups the letter from the Home Office along with the other documents concerning address and identification. Two commented that they would register refused asylum seekers in the same way. The others did not comment on this.

Two of the practice managers think that they have received some information from the PCTs on registering people from these groups. One mentioned that there was a Local

Enhanced Scheme (LES) for registering these groups, but now the PCTs have stopped funding it.

Quality of service

All practices carry out surveys to assess the patients' satisfaction of the quality of the service; some practices carry out more than one.

All respondents could outline some of the recommendations that came out of those surveys. The main recommendations were all around access; such as later opening hours, and better access by phone. One Practice Manager also suggested improving the access to interpreting services. Most of the practices could outline some developments that they have introduced as a result of these survey findings.

Interpreting services

All practices offer access to interpreting services; services used were GRIP, CITAS, Global Solutions, Language Line, and PCT services. One mentioned that diversity of practice staff allows them to interpret for patients.

Most practices proactively provide this, with some being booked automatically when a non-English language patient makes an appointment. They did also mention the variation in availability and time taken for different language interpreters.

There doesn't seem to be any formal assessment of the quality of the interpreting services used. However, it is apparent that most practices do consider this issue of the quality of interpreting services and some try to get ad hoc feedback from patients or assessment by staff. There were also suggestions that there would be feedback from the patients, especially in the case of them not being satisfied.

None of the practices have received any direct recommendations about improving interpreting services from the PCTs. Some commented on there being a change of the interpreting company that the PCT use, resulting in a better service. The general feelings were that the service works. However, some problems with it were outlined and suggestions were that the PCTs should help in remedying these. The problem of interpreters being late was mentioned, as was the availability of interpreters with some experiencing long waits for interpreters of particular languages.

Front-line staff

Practice managers were generally positive about the current level of support that the front-line staff provides to patients from BME groups. There were comments about the ethnic diversity of staff and how this helps in understanding needs and perspectives of patients. There were also comments on training provided and tendency of staff to try to accommodate patient's requests where possible. However one practice manager reported that patients from BME groups expect too much from healthcare staff and would like all their problems addressed; not recognising that there are other services that are available to provide this support.

A4 Results – Cluster leads

Service Improvement Plans

All clusters had existing Service Improvement Plans (SIPs). SIPs are drawn up by the PBC Clusters and outline the intentions in developing and commissioning new services. The plans focus on different areas for each cluster, but most had plans around diabetes and anti coagulation. All cluster plans commented on shifting services into the community, which would be expected to address BME access issues. All cluster Chairs indicated that existing plans have been successful in improving services, and there were more developments envisaged for next year's plan.

None of the plans were expected to 'focus' on the needs identified by BME communities. However, most of the clusters expected their plans to include the needs of the BME communities by assessing the needs of all cluster patients. It was noted by one cluster lead that the cluster has no role for overseeing GP practices; this was the PCTs' role.

When asked how the PBC Clusters are assessing the needs of the BME population for the development of their Service Improvement Plans there were differing responses between the clusters. Two clusters had quite comprehensive approaches for assessing BME groups' needs; using different sources such as existing surveys, voluntary organisations, user groups and public meetings.

One of the cluster leads commented that they will not seek outside opinion. Instead they will focus on adapting services that can be easily changed. A reason for this is that they can make better use of limited resources by concentrating on issues where there is a high likelihood of achieving positive results.

One of the cluster Chairs responded that they would assess the patient needs themselves, preferring their own interpretation of patient needs instead of formal assessment. There were also some comments about the difficulty of engaging with patients and the public in the context of the limited manpower at their disposal.

Turning to the specific issue of consulting patients and the voluntary sector on the development of the SIPs there was uncertainty around who produces these, and therefore who should conduct the consultations. One respondent suggested that the SIP is produced by the PCTs, who should have consulted with relevant parties in the development of the plan. Another cluster said that they do not use the SIP and added that it would be unrealistic to comment at every stage of this process.

Those clusters that did, or will, consult in the development of the SIP varied in their approaches. One respondent outlined plans to put up details of service intentions in surgeries, encouraging patients to attend groups or write in with their views. Another respondent said that they already do a sort of consultation informally. They might consider formalising this in the future by using voluntary organisations and key community members in focus groups. Another respondent commented on their intentions to have a full consultation, as well as including users in the service improvement and change process.

Activity of the PBC Clusters

When asked about their cluster's funding arrangements for improved access for patients from BME communities, two of the respondents commented that it was not the role of the clusters to address this. All but one of the respondents said that primary care access issues applied to more than just BME groups. Two respondents said that they would look to the PCTs to address access issues.

One of the respondents said that their cluster funds practices to promote access for vulnerable groups. Practices are targeted to provide enhanced primary care services.

There was a general feeling that it was not the role of clusters, nor was it within their power, to influence the quality of shared services (such as interpreting). Most commented that the quality of services should be equal across all practices.

One respondent commented that the patient has a choice in utilising existing services and the GP cannot force their use.

When asked about whether the PBC Clusters will encourage practices to produce information on access and quality standards that GPs should be providing, there was a similar uncertainty around whether this was in the PBC Clusters remit or ability. One commented that information leaflets are part of the agreement between practices and the PCTs, not between the PCTs and the PBC Clusters. Others also underlined the fact that this is a GP issue and not within the role of PBC Clusters to influence.

None of the respondents said that the leaflets would be provided in different languages. Costs were outlined as an issue in providing information in different languages. Also, one of the respondents suggested that a way of providing information in different languages is to sign-post the availability of interpreting services.

Other issues

The respondents were asked about whether their PBC groups were going to consult with BME patients about their service needs as part of their plans for improving patient choice. All said that they intended to. One respondent outlined that they would consult with patient groups/panels and the BME Health Forum to inform their plans. One of the respondents ensured patient choice through the Choose and Book system. Other respondents did not outline how they were going to approach this.

When asked how the PBC Clusters could best work across NHS boundaries and with patients to redesign services there were no strong suggestions coming across from any of the respondents. One commented on the need to involve the public in service design. Another respondent added that patient involvement is hard in primary care and it was difficult to envisage how it will deliver change.

A5 Results – CEC/PEC Chairs

Current activity of the CEC/PEC

The issue of improved access for health services is high on the agenda for both CEC/PEC. Kensington and Chelsea PCT (K&C PCT) is currently surveying patients to understand issues around accessing primary care. Westminster PCT (WPCT) is looking to increase opening hours. Neither of these initiatives is specifically targeted at improving access for people from BME communities, although improvements are expected for all patients. It is likely that in the future there will be financial incentives introduced for Practice Based Commissioning (PBC) Clusters to help improve access.

Regarding improving access for asylum seekers and refugees the WPCT PEC Chair suggested that improved access could be made through interpreting services. K&C PCT intends to implement GP registration and appointment booking in Accident and Emergency (A&E) departments to identify and redirect patients using A&E as a primary care service. Both CEC/PEC Chairs emphasised the independence of each general practice in running their businesses, and expected that practices would be registering patients appropriately. The CEC/PEC would address situations of poor access or where practices are not fulfilling their contractual obligations.

Role of the BME Health Forum

The CEC/PEC Chairs supported the idea that the BME Health Forum should have a role in improving BME communities' access to primary care services. One Chair suggested that the role should be one of influencing and enhancing relationships between the PCTs and the PBC Clusters, ensuring that the priorities of both groups are met. Enhancing the profile of the BME Health Forum will be beneficial in improving services.

The other Chair stressed that the BME Health Forum should take a pro-active role directly identifying and sharing good practice. This approach would get the most immediate results; influencing policy will be a longer process.

The Forum could actively identify general practices that are popular and accessible to patients. Lessons from these could be shared with other GPs. On the information side, the BME Health Forum could have a role in health intelligence, using information from the available systems and developing maps with demographic information.

Actions to improve access

One of the Chairs suggested that the BME Health Forum should be finding areas of good practice in individual general practices (or clusters) and assisting in rolling that out. In addition, they should be identifying problematic surgeries to work with them to improve service access.

The BME Health Forum could also assist in helping the PCTs become more aware of the real barriers affecting these groups. There is also a suggestion that the BME Health Forum could help people from BME communities navigate the NHS and sign-post relevant services to them.

Patient Pathways

Turning to the issue of ensuring patient pathways are suitable for patients from BME communities, one of the Chairs outlined the need for BME groups to be involved in the planning of care pathways from the start. Patients from BME communities can assist by suggesting or identifying areas in need of attention and there needs to be a strategy to ensure that this can happen. Patient experiences can also be considered in improving services and designing pathways.

Other approaches suggested to lead to improved care pathways for BME patients were: information in different languages; ensuring people are aware of symptoms; access to interpreting services; being aware of the different needs of individuals; knowing that there may be more time needed for particular consultations; explaining the concept of referrals to the patient; identifying people at high risk; involving the patient in software development.

Registering asylum seekers and refugees

Looking at the issue of registering asylum seekers and refugees on to practice lists, both Chairs felt that the GPs would support discussions around this. One of the Chairs could not give any suggestions for ways to approach GPs about the registration of asylum seekers.

The other Chair outlined that the BME Health Forum might approach the PBC groups through their quarterly meetings; ensuring that PCTs keep BME issues on the agenda when they meet. It was noted that some GPs will be more supportive than others. Also, it was mentioned that there is a need for BME groups to report any controversial issues in this area to the CEC/PEC.

Interpreting services

Turning to the issue of how to work with GPs to improve interpreting services, Kensington and Chelsea PCT are looking into developing polyclinics which would have interpreters present at all times. Again the need for BME communities to report any negative experiences to the CEC/PEC was expressed. This would allow the CEC/PEC to investigate and solve any recurring problems with particular GPs.

Enhancing the quality of consultations

When asked how the BME Health Forum should work with local GPs to enhance clinical services to BME groups one of the Chairs suggested that they should advertise messages to the BME communities. These could be around encouraging patients to request more time when booking appointments if they expect the standard consultation period to be insufficient for them. They could also help raise awareness of the availability of interpreting services.

The other Chair suggested that the BME Health Forum could assist in identifying problems within the system and working with stakeholders to develop performance management tools accordingly. PALS was suggested to be a good way of reporting back issues of concern to the CEC/PEC and PCT.

A6 Results - Focus group

The results of the two separate focus groups were very similar, and raised the same issues and concerns.

Opinions on sample representation

The discussants felt that the sample was representative of the BME communities as a whole. There was adequate participation from both boroughs, and the age, sex and ethnic mix of participants was satisfactory.

As participants were randomly selected the feeling was that the sample was not dominated by particular characteristics (e.g. patients who have had negative experiences and use this survey as an opportunity to complain). However, as the sample was selected on the basis of recent use of GP services (within the last year), it is likely to be biased towards people who use GP services more often. This would include people from deprived backgrounds and who may have higher risks of other social issues. (this sentence is not clear) There was also limited engagement with people who have had been unable to register with a GP (group 4 in the analysis). There was some feeling that this could mean few asylum seekers or refugees within the two boroughs are unregistered.

Differences in expectations between patients from BME communities and non-BME patients

The groups agreed that there were differences in the expectations of patients from BME communities, compared to the expectations of patients from non-BME communities. Further to this, the groups suggested that there were strong differences between newly arrived patients from BME communities and those who have been in the UK a long time. There was no discussion on how a ‘newly arrived’ person would be defined.

Although most of the issues raised in this part of the discussion were related to the newly arrived patients, the issues still apply to varying degrees to patients who have been in the UK for some time. The extent to which they apply depends on the issues such as how long they have been in the UK and how many generations of family have been in the UK, particular cultural issues of their specific community, and the extent to which they have integrated in UK society.

It is possible that newly arrived BME groups expect higher standards of healathcare. This may be related to general expectations of higher standards of UK services when people are coming from lesser developed economies. Patients new to the NHS system

also expect to see specialists sooner and referrals to be easier. They may also be more inclined to go straight to the doctor with any health concerns, rather than use over the counter medicines or monitor the progress of their condition.
However, these preconceptions (if they exist) are not all likely to be positive. Often, patients from BME backgrounds, particularly the newly arrived, feel that they do not have rights and expect to be treated badly by reception staff. They may question how seriously the doctor will consider their issues, and they may not expect the consultation to be confidential. It was also suggested, that there are some particular problems with the issue of mental illness, where patients from BME communities fear that they will be diagnosed as having a mental illness.

Reasons for these differences in expectations between newly arrived and long term UK patients were discussed. The issue of newly arrived patients being used to a different, privately funded health system may help understand the background to these differences. In such a system it is more likely that the paying patient may have more power in the professional/patient relationship. The defined transaction of money for a service may place onus on the service provider (e.g. doctor) to be more responsive to the patient’s needs or requests - however limited the clinical need may be.

There were also suggestions that this patient-led relationship in other health systems would more likely lead to longer consultations, more respectful interactions, and more frequent granting of referral requests (sometimes regardless of clinical need or cost effectiveness).

It is important to note that discussions around these possible preconceptions focused on BME communities as a group. Within the group there may be stark differences in behaviour and perceptions. It is also important that these preconceptions (positive and negative) are not fixed; they will be shaped by experience and influenced by others.

It was also noted that certain BME communities might grant greater esteem and respect to doctors and other highly qualified professionals. This may impact upon the patients’ willingness to question, challenge, or even interact with the doctor. On the other hand, it may also raise the expectations of the outcome of the consultation.

When discussing potential reasons why these expectations are not being met the group touched on cultural differences between patients from BME communities and non-BME patients. Language differences inhibit the ability to fully express detail of symptoms; where non-fluent English speakers may not be familiar with terms used to describe physical feelings or symptoms (i.e. dull ache, throbbing pain, etc). On a related issue, language and communication culture may put patients from BME backgrounds at a disadvantage in being able to interact with the doctor in a concise manner.

The groups then discussed the potential mechanisms and approaches in managing these expectations. It was strongly suggested that any measure to address this mismatch should be a two-way process. Patients should be educated about their rights and about what is expected from them by health care professionals. Health care professionals should be educated about the different needs of patients from different backgrounds. Further than this, it was suggested that the reasons for different behaviours should be shared to enhance the understanding of the underlying causes of this diversity.

Expectations of healthcare professionals

When discussing the expectations of healthcare professionals the group emphasised that the issues applied to all layers of the healthcare workforce, from receptionists and frontline staff through to managers and service planners.

The groups outlined that there are some expectations and pre-conceived ideas in the health workforce about patients from BME communities; these were often likely to be negative. They suggested that healthcare professionals see patients from BME groups as:

- Wanting services because they are free
- Not understanding the healthcare system
- Having language and communication problems
- Needing more time for consultations
- Having particular heath problems
- More likely to bring their own cultural way of dealing with health issues

In addition the group suggested that some health professionals are likely to feel that patients from BME communities should learn to speak English, and that using interpreting services is counter productive in the long term. They also suggested that some health professionals assume that the newly arrived should be grateful for the health care that they receive. Similarly they may expect patients from BME communities to be passive recipients of healthcare, gratefully receiving the care provided. The discussions went on to suggest that these pre-conceptions are perpetuated by the media reporting of immigration issues and use of public services.

There was also a long discussion around the tendency of healthcare professionals to want to treat every patient the same, despite the very different needs and characteristics of particular groups. This equal treatment actually leads to unequal service quality, as patient groups have differing abilities to engage in, and benefit from, that service. This situation leads to a vicious circle where lower quality service, arising from inability to engage in the service, results in higher uptake of service through revisits and lack of trust in referral decisions.

Discussions turned to how these preconceived opinions can be addressed and managed. Suggestions were around the training of doctors and of the need for more doctors from BME backgrounds. However, the group acknowledged that there were already a high proportion of healthcare staff with BME backgrounds, and that therefore this issue is attributable to the healthcare system rather than the individuals who work within it.

The group also suggested that patient forums might help in encouraging the healthcare staff to engage in a more effective dialogue with the patients. It was also suggested that the GP contract might contain some criteria around engagement with the BME communities.

Ways forward

The group outlined that two approaches were needed in managing these pre-conceptions and expectations. There is a need to engage with the BME communities, possibly through the voluntary sector, to inform expectations and service use behavior. Similarly, practice staff and other primary care professionals need to be engaged with.

There were suggestions that there should be promotional activities on how to use health services, similar to those activities used in health education and promotion. Achieving a cultural change in the way that health services are used and accessed was seen to be very high priority. Empowering community groups to assist in this goal is important. There were also some suggestions of using creative media to assist in these promotional efforts.

The BME Health Forum is in a good position to influence the BME communities through their links with the various community groups. However, the sustainability of the Forum also needs to be considered. The potential role of the PCTs' Patient Advice and Liaison Service (PALS) was also mentioned, as was the possibility of adopting peer education approaches.

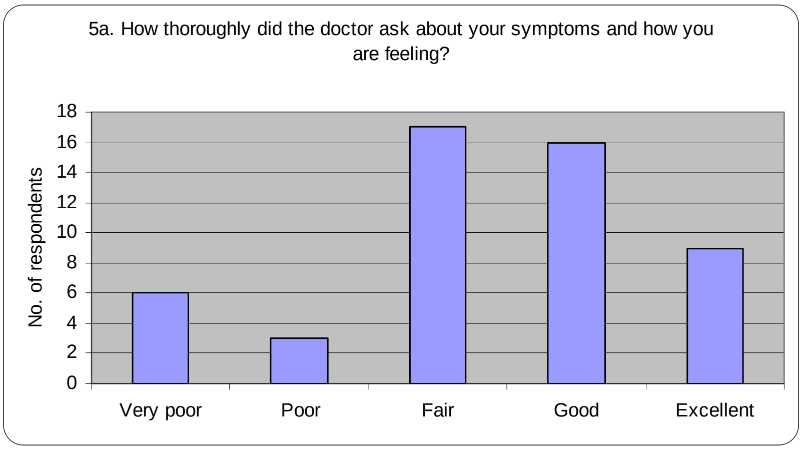
Other suggestions were that GPs could work with community groups to find ways of dealing with the non-medical issues that some patients present at GP surgeries (such as housing issues). It was also acknowledged that any intervention or campaign should use clinicians, as they have a lot more credibility when talking about services.

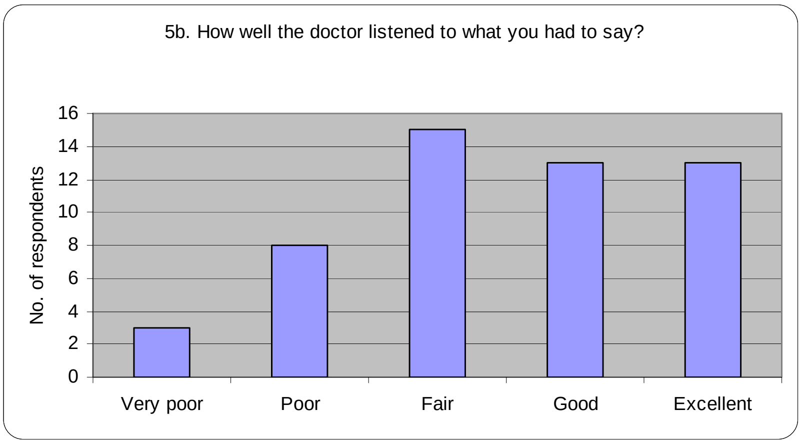
Turning to options in influencing healthcare providers the group commented that not enough of them perceive that there is a need to improve access and quality for patients from BME communities. The group suggested that training delivered to all healthcare staff, especially GPs, would help address any pre-conceptions or prejudices.

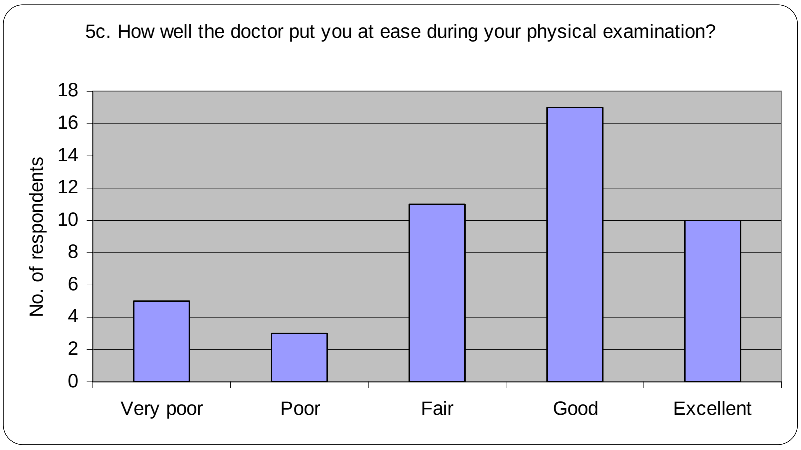
The group mentioned that there is a need to influence the leads of PBC Clusters and establish relationships with them; but they were unsure of what will motivate them. One proposed option was to use GP practice peer groups to raise awareness, such as practices that have successfully addressed the issue.

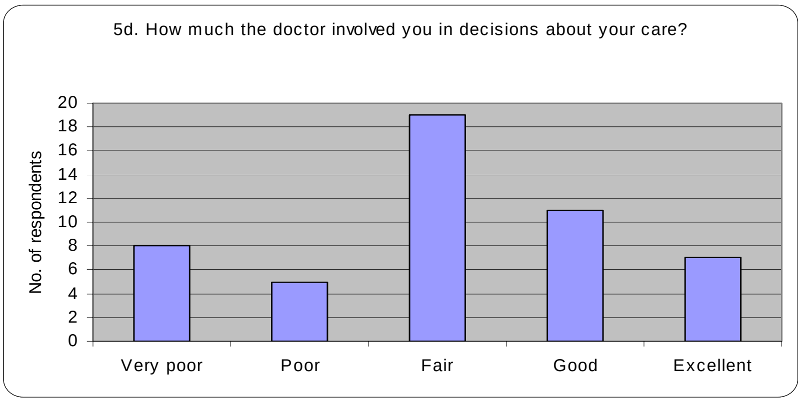
Appendix 2

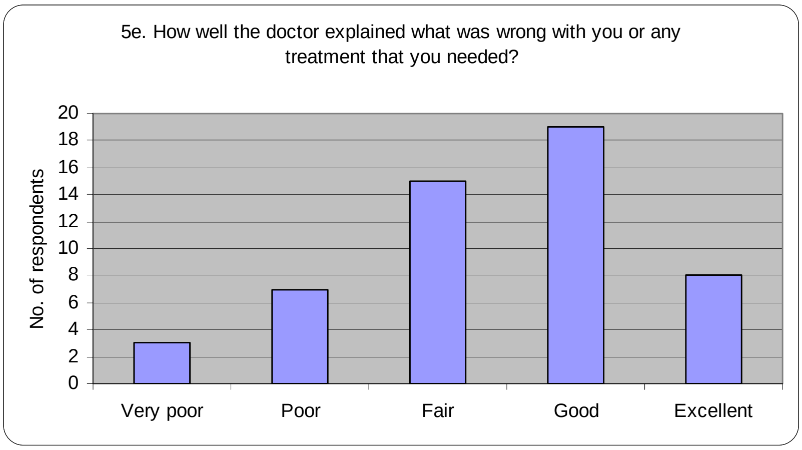
Graphs and results from the Patient questionnaire

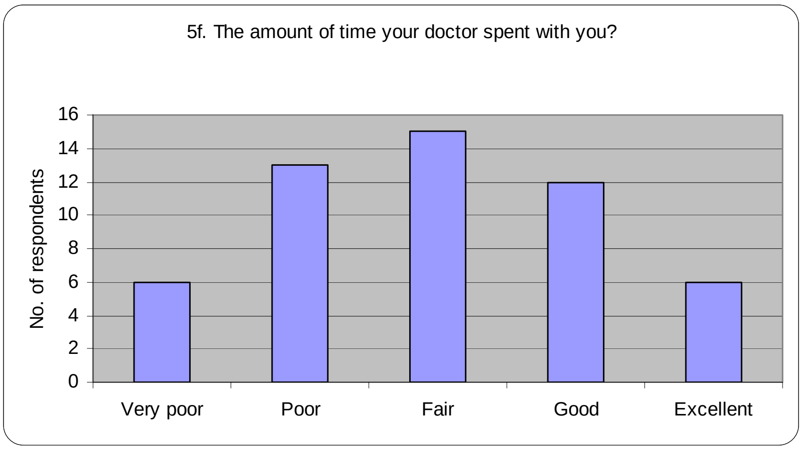


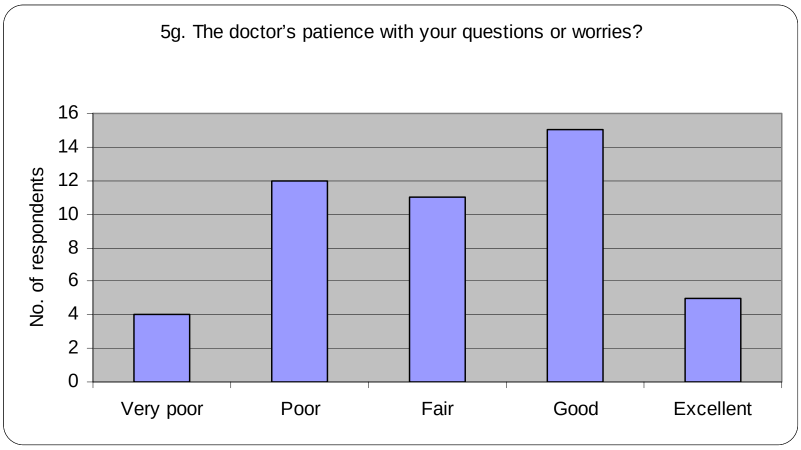





5d. How much the doctor involved you in decisions about your care?


5e. How well the doctor explained what was wrong with you or any treatment that you needed?


5f. The amount of time your doctor spent with you?



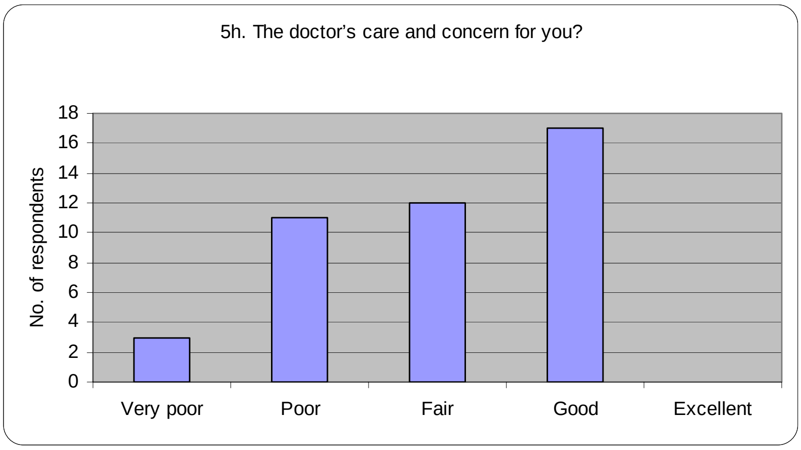


Table showing the percentage responses for each of the quantitative questions in the patient questionnaire.

**Group 4 contains 6 patients who have not registered with the doctor – due to small numbers and differences in questionnaires used for some of these groups their responses are not included in this table*

		All groups		Group1	Group2	Group3
Total number within each group		**49***		**28**	**13**	**8**
1. How many times have you seen a doctor in your GP practice in the past 12 months?	0					
	1 or 2	24.5		25.0	30.8	12.5
	3 or 4	18.4		21.4	15.4	12.5
	5 or 6	16.3		21.4		25.0
	7+	40.8		32.1	53.8	50.0
4. If you need to see a GP urgently, can you normally be	Yes	34.7		39.3	7.7	62.5
	No	42.9		42.9	53.8	25.0

		All groups		Group1	Group2	Group3
Total number within each group		**49***		**28**	**13**	**8**
seen on the same day?	DK	20.4		14.3	38.5	12.5
5a. How thoroughly did the doctor ask about your symptoms and how you are feeling?	Very poor	12.2		7.1	15.4	25.0
	Poor	6.1			7.7	25.0
	Fair	30.6		28.6	46.2	12.5
	Good	32.7		46.4	15.4	12.5
	Excellent	16.3		14.3	15.4	25.0
	Does not apply	2.0		3.6		
5b. How well the doctor listened to what you had to say?	Very poor	6.1		3.6		25.0
	Poor	16.3		7.1	46.2	
	Fair	26.5		32.1	15.4	25.0
	Good	26.5		28.6	23.1	25.0
	Excellent	24.5		28.6	15.4	25.0
	Does not apply					
5c. How well the doctor put you at ease during your physical examination?	Very poor	10.2		3.6	15.4	25.0
	Poor	6.1		7.1	7.7	
	Fair	22.4		25.0	15.4	25.0
	Good	30.6		32.1	38.5	12.5
	Excellent	18.4		21.4	7.7	25.0
	Does not apply	12.2		10.7	15.4	12.5
5d. How much the doctor involved you in decisions about your care?	Very poor	16.3		7.1	15.4	50.0
	Poor	8.2		7.1	15.4	
	Fair	36.7		39.3	46.2	12.5
	Good	20.4		25.0	15.4	12.5
	Excellent	14.3		17.9	7.7	12.5
	Does not apply	4.1		3.6		12.5
5e. How well the doctor explained what was wrong with you or any treatment that you needed?	Very poor	6.1			15.4	12.5
	Poor	14.3		10.7	23.1	12.5
	Fair	24.5		28.6	23.1	12.5
	Good	38.8		42.9	23.1	50.0
	Excellent	16.3		17.9	15.4	12.5
	Does not apply					
5f. The amount of time your doctor spent with you?	Very poor	12.2		7.1	15.4	25.0
	Poor	24.5		17.9	46.2	12.5

		All groups		Group1	Group2	Group3
Total number within each group		**49***		**28**	**13**	**8**
	Fair	26.5		39.3		25.0
	Good	24.5		21.4	30.8	25.0
	Excellent	12.2		14.3	7.7	12.5
	Does not apply					
5g. The doctor’s patience with your questions or worries?	Very poor	8.2		3.6	15.4	12.5
	Poor	24.5		14.3	46.2	25.0
	Fair	20.4		21.4	15.4	25.0
	Good	28.6		39.3	15.4	12.5
	Excellent	18.4		21.4	7.7	25.0
	Does not apply					
5h. The doctor’s care and concern for you?	Very poor	6.1			15.4	12.5
	Poor	20.4		7.1	46.2	25.0
	Fair	20.4		28.6	15.4	
	Good	34.7		39.3	7.7	62.5
	Excellent	16.3		21.4	15.4	
	Does not apply	2.0		3.6		
Sex	Male	30.6		35.7	15.4	37.5
	Female	69.4		64.3	84.6	62.5
Age group	16-21	8.2		14.3		
	21-35	22.4		21.4	23.1	25.0
	35-50	30.6		35.7	30.8	12.5
	50-65	22.4		14.3	23.1	50.0
	65+	14.3		10.7	23.1	12.5

**where percentages do not total 100 this is due to non-responses*

References

Acheson D. Independent inquiry into inequalities in health. HMSO 1988

Adamson J, Ben-Shlomo Y, Chaturvedi N, Donovan J. Ethnicity, socio-economic position and gender – do they affect reported healthcare seeking behaviour? Social Science and Medicine; 57, (2003) 895-904.

Department of Health and Social Security (1980) Inequalities in Health: Report of a Working Group Chaired by Sir Douglas Black. DHSS, London.

Dixon A, Le Grand J, Henderson J, Murray R, Poteliakhoff E. Is the NHS equitable? A review of the evidence. LSE Health and Social Care Discussion Paper Number 11. 2003.

Dixon-Woods et al. Vulnerable groups and access to health care: a critical interpretive review Report for the National Coordinating Centre for NHS Service Delivery and Organisation: R & D (NCCSDO) April 2005, revised August 2005

Doescher M, Saver B, Franks P, Fiscella K. Racial and Ethnic Disparities in Perceptions of Physician Style and Trust. Arch Fam Med. 2000;9:1156-1163.

Mold F, McKevitt C, Wolfe C. A review and commentary of the social factors which influence stroke care: issues of inequality in qualitative literature. Health and Social Care in the Community. 11 (5), 405–414. 2003

Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient physician racial concordance and the perceived quality and use of health care. Arch Intern Med 2000;9:1156–63

Acronyms

BME	Black & minority ethnic
CEC	Clinical Executive Committee
GP	General Practitioner
GPAQ	General Practice Assessment Questionnaire
K&C	Kensington & Chelsea
KCW	Kensington, Chelsea & Westminster
MRC	Migrant Resource Centre
PALS	Patient Advice & Liaison Service
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PEC	Professional Executive Committee
SES	Socio-Economic Status
SIP	Service Improvement Plan
The Forum	BME Health Forum

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