

**No Patient Left Behind:** how can we ensure world class primary care for black and minority ethnic people?

Report of the group chaired by  
Professor Mayur Lakhani CBE

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## Foreword from Professor Mayur Lakhani, Chair of the BME Review Group

In July 2007 the Secretary of State for Health, Alan Johnson, asked me to undertake a review of why patients from black and minority ethnic (BME) groups find it more difficult to access GP services than white populations. There was justified concern about the findings in the first national GP patient survey conducted in January 2007 – the biggest of its kind – which showed that BME patients were less satisfied with GP access. I was delighted to accept the invitation to understand this issue better and find some answers.

I established an expert group to give me support and advice. I also commissioned a literature review, focus group studies, undertook visits to PCTs and practices, and met with community groups and leaders. I would like to thank the members of the group and the Department of Health (DH) secretariat who have given me the necessary support to undertake this important work.

I found four main inter-linked reasons for dissatisfaction: firstly, there is a substantial communication problem between patients and practices caused by language and culture barriers. Secondly, the disease burden is greater in BME patients who tend to have a poorer health status. Thirdly, the quality of GP services is too variable and finally, the expectations of BME patients are different. These factors result in a healthcare need that is not fully matched by existing services, resulting in dissatisfaction.

My overall conclusion is that a significant proportion of BME patients are struggling to get the healthcare they need. They are afraid to complain about poor services and unable to exert real influence on improving local services. There is therefore an urgent need to build trust between BME communities and their local NHS.

There is a deficit in the commissioning and procurement of primary care, such that services are not provided for or planned for according to need. The combination of these factors could have the effect of exacerbating health inequalities.

PCTs and practices are working in demanding circumstances and are trying to sustain a service in the face of sometimes overwhelming problems. They need support to improve the situation and this report suggests ways in which this can be done, but it is their responsibility as commissioners and providers to solve this problem on behalf of their local communities. They should be held to account if major improvements are not delivered quickly. All patients at these practices are affected, not just BME patients.

This is a complex problem for which there are no easy solutions. However, improvement is distinctly possible through the concerted action outlined in this report. My approach is based on the fundamental premise that the NHS should provide services which are personalised to meet the identified needs of patients. More responsive and personalised care will mean benefit for all members of the community – black and white – through the lessons learnt in service development.

Solutions to this are not about separate services for BME groups but a model of flexible personalised care that is part of mainstream healthcare. This approach raises the primary care bar for all NHS patients irrespective of their race, culture or religion. This is why we have worked closely with David Colin Thomé's National Improvement Team (NIT), which has been examining the generic underlying issue of general practice responsiveness. I must also emphasise that solutions should seek to promote integration and social cohesion in communities, for example through advocating the value of English as a second language for the working age population.

Our recommendations focus on:

- supporting patient 'choice and voice' within BME communities
- stronger, equitable commissioning for diverse populations based on local needs assessment
- better regulation
- routine ethnicity data collection and compliance by NHS trusts with race relations legislation
- stronger leadership and commitment on BME issues
- improving the quality of general practice
- supporting PCTs and practices by establishing a national project to spread best practice and innovation in BME primary care
- training of primary healthcare staff and developing the practice receptionist role to become a 'patient navigator' – a highly skilled person focused on customer skills
- supporting and nurturing a diverse workforce.

As the report of the NIT has found, there remain unacceptable variations in access to GP practices and the responsiveness of GP services. I was impressed by the commitment shown by people and organisations we met. They are keen for work on this issue to gather momentum. This report should therefore act as a catalyst for the delivery of much needed improvements.

It is essential that progress is monitored towards achieving equality. Within three years, we would like to see the negative satisfaction gap that BME patients report narrowed or abolished. If sufficient progress is not achieved then stronger intervention should be considered, including action by the regulator.

New approaches are needed and research in BME health should be accelerated to find innovative solutions and spread best practice.

The interim report on the NHS Next Stage Review emphasises the importance of personalisation of care. This offers an opportunity to outline a culturally sensitive primary care service for all that is focused on delivering better health outcomes through managing difference.

This report is purposely written in an accessible style because I want it to be read and used widely. When I met BME community leaders and patients in the course of my investigation, I was struck by their level of concern and strength of feeling. I commend this report and its recommendations to the NHS, independent contractors and community leaders and urge them to come together to take strong action to implement its findings.

## Executive Summary

Fair and equal access to services is a right of every NHS patient, regardless of their ethnic origin or where they live in the UK.

Sometimes this means providing additional or different kinds of services, for example professional interpreters and patient advocates, to make sure all sectors of society are able to benefit from the NHS in the same way and to help patients make informed choices about their treatment and care options.

It is up to individual PCTs and GP practices to work out the make-up of their local patient populations and design and commission services that best meet their needs.

The problem is that this isn't happening as well as it should. The first national GP patient survey, conducted in January 2007, found that a large proportion of BME patients, particularly Bangladeshi patients, are less happy with access to primary care services than white patients, sometimes even within the same practice.

That's why the Secretary of State for Health asked Professor Mayur Lakhani to set up a review team to find out more and suggest a way forward.

The team visited GP surgeries and PCTs in areas of the country where there are lots of BME patients, and talked to staff and patients about the local health services on offer. It also set up focus groups of BME patients to get more information and it looked at key research evidence.

The team's conclusion is that there is a mismatch between the health needs and requirements of BME people and the services on offer, leading to dissatisfaction and unmet need.

Access and responsiveness in primary care is an issue of major concern and services need to be improved quickly in order to build confidence and trust between the NHS and BME communities. To do this, the local NHS needs to continue to become much better in the planning of local services based on the needs of its population. Steps should be taken to improve the quality of general practice and for BME patients to have a greater say in their healthcare.

The review is clear that the solutions to this are not about separate services for BME groups but a model of flexible personalised care that is part of mainstream healthcare.

To help practices and PCTs understand what needs to be done, the team has identified 10 key factors that need addressing. Many of these are generic issues applicable to all people but some are specific to BME groups.

- 1 Dysfunctional communication between healthcare organisations and patients: healthcare organisations need to communicate better with BME people.
- 2 Lack of choice and voice: patients are unable to choose between practices because of limited local services and are unable to exert real influence on planning for better services.
- 3 Community understanding of the healthcare system: many patients have a limited understanding of the services offered by the NHS and how to access them, which affects their health-seeking behaviour.
- 4 Inflexibility in the system: this acts as a barrier to access.
- 5 Quality of general practice: variation in quality encountered by BME patients causes frustration and dissatisfaction.
- 6 Continuity of care and the doctor-patient relationship: this can be of particular importance to BME patients, yet difficult for them to attain.
- 7 Importance of receptionists: patients can place undue pressure on receptionists, yet receptionists are key to patient access.
- 8 Worse health status: BME patients are more likely to report that they are in poor health and have a greater burden of disease.
- 9 Impact of wider issues on health: worries about housing and unemployment are inextricably linked to health.
- 10 Poor NHS links with local communities: leads to fragmentation of care due to lack of information and effective partnership working.

Each of these factors poses challenges. The first step is for practices and PCTs to acknowledge the difficulties faced and make a real and measurable commitment to addressing them. They should work closely together to demonstrate good practice. They should talk to patients about what needs to be done and act on what they are told.

The DH can support them in their efforts by increasing awareness about BME patients' issues throughout the NHS, setting the right policy framework, supporting additional training for healthcare professionals and rewarding practices that perform well.

Collecting data on ethnicity will also help PCTs to better understand the make-up of their local patient population, so that they can commission appropriate services. This is one of the key recommendations.

In addition, world class commissioning (WCC) will strengthen PCTs as commissioners so that they can provide local people with more choice and influence over services and dramatically reduce health inequalities.

The advisory board for the NHS Next Stage Review will use this report, along with other sources, to inform development of primary and community care services so that the DH vision of a culturally-sensitive primary healthcare system can be fully realised.

The report reinforces the key theme of personalisation which is central in the NHS Next Stage Review. More responsive and personalised services tailored to the identified needs of patients will benefit all members of the community.

## Recommendations

The report recommends a series of actions by the DH, PCTs and individual practices to embed good practice and ensure equity of access and responsiveness in primary care for BME patients. These recommendations should be regarded as good professional and managerial practice.

### Practices

- 1 Use the examples of good practice to deliver high quality care for BME patients.
- 2 Work more closely and collaboratively with the PCT to ensure BME patients have excellent access to services that respond to their needs.
- 3 Work with patients to establish patient partnership groups and forge positive relationships.
- 4 Collect data as indicated in the national minimum ethnicity dataset.
- 5 Exercise leadership and commitment to provide a tailored and flexible appointment system with sufficient capacity to be responsive to patients' needs.

### PCTs

- 6 Work to develop competencies as world class commissioners to ensure equitable commissioning of primary care, including establishing programmes of citizen engagement and health literacy.
- 7 Ensure they are fully compliant with the Race Relations (Amendment) Act (2000).
- 8 Establish specific initiatives to improve professional and organisational standards in GP practices.
- 9 Work with practices to develop an appropriate programme for training staff in good 'customer care', including developing 'patient navigators'.
- 10 Analyse the results of patient surveys, including segmentation of the results, and agree action plans with practices to implement any necessary changes.

### SHAs

- 11 Provide leadership in primary care and make PCTs accountable for delivering high quality services.

### DH

- 12 Support PCTs and practices to implement the recommendations of the report by establishing a national collaborative project.
- 13 Strengthen leadership on BME issues.
- 14 Promote ethnicity data monitoring in primary care and measure progress towards achieving equality.
- 15 Ensure compliance by the NHS with the Race Relations (Amendment) Act (2000).
- 16 Focus on getting the best from general practice everywhere by working with the Royal College of General Practitioners (RCGP) on a quality practice accreditation scheme.

## Introduction

Accessible and responsive primary care is the cornerstone of a 21<sup>st</sup> century health system. It is a key issue for all groups, not only BME people. For this reason, access remains a priority for the NHS, as set out in the Operating Framework for 2008/09<sup>1</sup>.

The framework document states: “Improving access to services will not only help to improve the patient’s experience but will deliver real improvements in health outcomes. Access to services at the time and place that people want remains a key litmus test of the public’s views of the NHS...”

The Operating Framework and interim report on the NHS Next Stage Review set out specific commitments to develop new services that support more convenient access, particularly in areas of greatest need. PCTs also need to work with GP practices to improve patient satisfaction with primary care services.

The GP patient survey found that BME groups are particularly less satisfied. This is consistent with previous research which has shown that BME groups report less positive experiences and lower satisfaction with primary care services<sup>2</sup>. It is also well known that access is poorer for disadvantaged communities, for example where there are geographical or socio-economic challenges<sup>3</sup>.

Improving access for disadvantaged groups and tackling health inequalities are key priorities for the NHS. This is the context of this report which examines the reasons for dissatisfaction within BME groups and proposes action to improve the situation.

Ethnicity can be defined as ‘shared origins or social background; shared culture and traditions that are distinctive, and maintained between generations, and lead to a sense of identity in groups; and a common language or religious tradition’<sup>4</sup>.

Everyone belongs to an ethnic group including ‘white’ people. This review uses the classification of non-white ethnic groupings<sup>5</sup> as used in the census by the Office of National Statistics.

All NHS patients regardless of where they live now, where they were born or their ethnic origin, have the right to expect fair and equal access to primary care services that are responsive to their needs. Tailoring services to individual need is a key task for the NHS as set out in the interim report on the NHS Next Stage Review, but this can pose enormous difficulties for local services.

The review group is clear that the solutions to this are not about separate services for BME groups but a model of flexible personalised care that is part of mainstream healthcare.

1 The NHS in England: the Operating Framework for 2008/09. DH, December 2007

2 Campbell JL, Ramsay J, Green J. Age, gender, socioeconomic, and ethnic differences in patients’ assessments of primary health care. *Qual Health Care*. 2001;10: 90- 95

3 Choosing Health: <http://www.dh.gov.uk/en/PublicHealth/Choosinghealth/index.htm>

4 Gill PS, Kai J, Bhopal RS, Wild S. Health care needs assessment: black and minority ethnic groups. <http://hcna.radcliffe-oxford.com/bemgframe.htm>

5 The Office of National Statistics: [http://www.statistics.gov.uk/about/Classifications/ns\\_ethnic\\_classification.asp](http://www.statistics.gov.uk/about/Classifications/ns_ethnic_classification.asp)

## The GP patient survey found that BME groups are less satisfied

In 2007, the DH conducted the first national GP patient survey. It was sent to five million people selected at random from GP practices' lists of NHS patients. Nearly half (2.4 million) responded making it the largest ever survey on patient satisfaction in primary care.

Results showed the majority of patients are satisfied with access to primary care. However, it also revealed 16%, a significant minority, are dissatisfied.

People from black and minority ethnic groups reported, on average, significantly worse access than white people.

The survey showed that overall:

- black populations are 5-10% less satisfied than white populations
- Asian populations are 5-10% less satisfied than white populations
- Bangladeshi communities are 20% less satisfied.

Not only was satisfaction significantly lower in practices with a high proportion of BME patients, even within the same practice satisfaction was lower among BME patients than white patients. For example, Bangladeshi patients were 3-11% less satisfied than white patients within the same practice.

Lower rates of satisfaction tended to be associated with large practices in deprived areas serving a significant BME community<sup>6</sup>. People registered at practices serving more than 10,000 patients in the most deprived third of the country rated their overall satisfaction with access at 76%. This compares to an average of 92% in practices serving fewer than 4,000 people in the least deprived third of the country.

## Responding to the survey

As well as the action on access taken through the interim report on the NHS Next Stage Review and the Operating Framework, the DH also took a number of other measures aimed at improving access and responsiveness. PCTs were asked to work with local practices to examine and respond to the survey findings and develop local action plans. At a national level, David Colin-Thomé was asked to lead a National Improvement Team (NIT) to work with the NHS and patients to develop a deeper understanding of the factors that contribute to excellent GP services and how good practice can be adopted across the system.

In addition to these generic actions, the Secretary of State for Health asked Professor Mayur Lakhani to lead a review focused on understanding the reasons for these results and recommending solutions in response to the worrying findings.

<sup>6</sup> GP Patient Survey, DH, July 2007 <http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/index.htm>

To gain a greater understanding of the causes of reported lower satisfaction rates, the review team did four things.

- It met with PCT and practice staff and patients to get an in-depth insight from the frontline.
- It commissioned qualitative research from Ipsos Mori, which ran a series of focus groups with BME patients.
- It looked at relevant research evidence on the issue <sup>7</sup><sup>8</sup><sup>9</sup><sup>10</sup>.
- It pooled all its members' expertise and knowledge to synthesise this report and put forward practical suggestions for improvement.

Professor Lakhani's team also worked closely with the NIT. Indeed, both teams' reports should be read together. Finally, it should be noted that the group's remit was not to undertake a systematic review or detailed research study or to consider specialised areas such as asylum and refugee care.

7 GP Access Issues Among Bangladeshi and Pakistani Communities - Qualitative Research, Ipsos MORI (2007)

8 Davey Smith G, Chaturvedi N, Harding S, et al. Ethnic inequalities in health: a review of UK epidemiological evidence. *Crit Public Health* 2000; 10: 377-408

9 Commissioned Review: Price Waterhouse Cooper 2007

10 Nazroo JY. *The Health of Britain's Ethnic Minorities*. London: Policy Studies Institute, 1997

## Factors contributing to responsive and accessible primary care for BME groups

Ten factors are identified that need attention. These are the most important issues put forward by the review team following their discussions with frontline staff and consideration of research evidence and focus group findings. They were expressed most strongly by patients, primary care professionals and PCT managers as contributing to patient satisfaction with primary care services. Research evidence is also highlighted where this is available, particularly around the importance of improving communication and engagement between BME groups and healthcare organisations.

What shone through clearly from the review was the need for PCTs to actively consider the profile of its local population in order to provide services appropriate to local needs.

We recognise that more work is needed to fully understand the complexity of the issue. New approaches are needed and future research in BME health should therefore focus on developing and testing interventions rather than demonstrating differences<sup>11</sup>.

Nonetheless this review represents an opportunity to develop expertise in commissioning world class primary care that is tailored to the needs of all patients.

Many of these factors are generic issues applicable to all people, while some are specific to BME groups.

### 1. Dysfunctional communication between healthcare organisations and patients

Patients who cannot speak English find it difficult to explain their current condition or overall health to an English-speaking doctor and this may mean they need longer appointment times to get the information across.



*If the GP is English and there is no interpreter then it is not always easy to explain what the problem is. If this happens then we have to make a few visits to see the GP.*

**Middle-aged Bangladeshi man, London**



*Asian people... Pakistani people, particularly our parents or grandparents have trouble communicating with their doctors, so it is a language issue.*

**Young Pakistani man, Birmingham**



Research shows that language barriers are a major cause of dysfunctional health encounters between BME patients and doctors. For example, BME patients are less likely than the general population to feel that they had sufficient time with their GP<sup>12</sup>.

<sup>11</sup> Kai, J. Safety and achieving equality amid diversity in healthcare. Br J Gen Pract, 2007; 57: 774-776

<sup>12</sup> Rudat K. Black and Minority ethnic groups in England. London: HEA, 1994

GPs face enormous barriers when communicating with BME patients who do not speak English. This makes the doctor-patient relationship and the diagnostic process often difficult and demanding and can lead to misunderstandings and wrong assumptions about the patient. Poor communication can also impact on the length of consultation time needed and can lead some BME patients to feel confused and disconnected from primary care.

A large proportion of South Asian patients register with GPs of similar ethnicity, but this does not automatically mean that effective communication takes place. Indeed, BME patients are still more likely to report a problem communicating with their GP. This means there are further significant barriers to communication other than the language spoken. Even British-born BME patients who speak fluent English report difficulties in accessing primary care, so it's important not to assume that language needs are always at the root of poor access.

BME patients should not be penalised for not being able to speak English. The provision of appropriate bilingual services should be considered an important healthcare need and a crucial contributor to better communication<sup>13</sup>.

Professional interpreters can also help, but only where patients have confidence in the interpreter and the advice they receive, and both parties are informed about the role of the interpreter.

Patient advocates can play a vital role in helping practices develop a better understanding of the language requirements of the community, so that they can respond positively to patients' needs.

PCTs should ensure that a range of high quality and accessible interpreter/advocacy services are available to support their populations.

### **Case study**

#### **Limehouse Practice, Tower Hamlets**

The Limehouse Practice in Tower Hamlets, East London, has a significant number of Chinese patients, many of whom are older and speak little or no English. The practice has recruited a Cantonese-speaking advocate who provides these patients with a range of services including:

- a drop-in where patients can get help booking appointments and understanding letters they have received from the hospital or other health professionals
- fixed sessions on Tuesday and Thursday afternoons so that patients can match appointments and receive an interpreted consultation with a trusted advocate
- telephone advice and help for patients and their families
- active involvement with local Chinese associations to raise awareness of services provided by the practice and help local people access primary care services generally.

13 Flores G. The Impact of medical interpreter services on the quality of health care: a systematic review. *Med Care Res Rev* 2005; 62: 255–299

### **Case study**

#### **The Shah Jalal branch of the Whitechapel Medical Centre, Tower Hamlets**

The Shah Jalal branch of the Whitechapel Medical Centre in Tower Hamlets has worked with its PCT and Local Strategic Partnership (LSP) to provide English for Speakers of Other Languages (ESOL) courses for BME groups. BME patients visiting the surgery are told about the courses, which are run in the practice's community room, and are encouraged to attend.

### **Case study**

#### **Bromley By Bow Health Centre, London**

Bromley By Bow Health Centre, London is using skills from within the community to help improve access to services, particularly via telephone. In addition to using multi-lingual reception teams, it has recruited a multi-lingual interpreter/advocate to provide a full-time interpretation service to BME patients, including during consultations in surgery, over the phone and at home. The role has been developed to include health promotion and the targeting of key groups for additional support, such as older people.

## **2. Lack of choice and voice**

A number of BME patients say they feel unable to complain about primary care services and find it difficult to exercise choice by switching practices when they are not satisfied with the service offered. Patients are also frightened they will be taken off a GP's list. In some areas this can be down to cultural inhibitions, but in others it is because there are too few practices operating in a particular area. Lack of capacity limits patient choice. This issue of 'choice and voice' affects both BME and non BME people.

Many BME patients get used to relatively low levels of service. Previous studies have shown that some ethnic groups have lower expectations<sup>14</sup>. BME patients told the review team they felt disempowered and unable to exert real influence on healthcare planning. They also said it was not clear whose role it was to fix the problem. They do not understand the local structure of the NHS and the role of the PCT and there is a sense of frustration at the slow rate of progress.

14 Ogden J, Jain A. Patients' experiences and expectations of general practice: a questionnaire study of differences by ethnic group. *Br J Gen Pract.* 2005;55:351-356

This points to a well-recognised need for greater patient and public engagement in commissioning decisions and a need to build confidence and trust between communities and the local NHS.

Achieving full engagement with local communities is an important aspect of improving the health of populations<sup>15</sup>.

### **3. Community understanding of the healthcare system**

Many patients have a limited understanding of the services offered by the NHS and how to access them. The system can be confusing for them. This can be further complicated by expectations formed from previous patient experiences such as using hospital accident and emergency services for primary care. As a result, patients can have unrealistic expectations about services. More needs to be done to explain the different options for the use of health services to encourage their more effective use, including improving understanding of primary care and the crucial role played by multi-disciplinary primary healthcare teams.

#### **Case study**

##### **Health Guides Project, East London**

This project trains groups of local people to act as health guides within their community, using their own language. The aim is to give accurate information and guidance to people from marginalised communities, including encouraging people to manage their own health and take care of themselves and their families.

It has proved immensely popular. One of the health guides said: “Such a simple idea – why has it never been done before?”

There is substantial interest from local people in training to be health guides, with a high completion rate of 90% and 200 local people have now been trained. They are local Bengali, Somali, Turkish/Kurdish, Congolese, Nigerian people from Tower Hamlets, Newham or Hackney.

Trained health guides have been running sessions in their communities since December 2004. They work in pairs to deliver sessions in community settings (community centres, schools, mosques, clubs) to groups of people from their own communities at different times of the day, evenings or weekends as appropriate.

More than 300 sessions have been delivered to date in East London, benefitting up to 5,000 people. In addition, the health guides have the opportunity to hear the concerns of local people at the grassroots level and feed the information back to decision-makers.

<sup>15</sup> Drinkwater C. Getting fully engaged with local communities. In *New Perspectives in Public Health*. Ed Sian Griffiths and David J Hunter. Radcliffe; Oxon 2nd edition 2007

Some BME patients do not always regard appointment times as rigid. This can result in high 'did not attend' (DNA) rates at practices where patients regularly turn up late and have to be turned away. It can then be hard for practices to deliver essential services such as immunisation.

The review team found some frustration within general practice at the number of missed, repeat or unnecessary appointments. There is merit in developing local agreements about rights and responsibilities between patients and providers so that both sides understand what to expect and what is expected of them. For example, a clear strategy to communicate practice policy on patients that fail to attend for appointments can help cut DNA rates.



*We are sometimes 10-15 minutes late and there goes our appointment and you have to start all over again.*

**Middle-aged Pakistani mother, Birmingham**



#### **4. Inflexibility in the system**

The process of making appointments and understanding choices and options appears to be hard for BME people, particularly where there are communication difficulties. This is frequently a source of conflict between patients and receptionists.

There are several steps in the primary care pathway that can be frustrating for patients because they do not offer sufficient flexibility to respond to patient need. The service is not sufficiently personalised.

For example, some practices operate rigid appointment booking processes, including telephone bookings, and this has an impact on patient satisfaction.



*While I'm satisfied with my GP's ability, I am 100% dissatisfied with the appointment system we have to go through. It's quite impossible even getting through to the surgery on your phone to book an appointment during the half-hour slot.*

**Middle-aged Pakistani mother, Birmingham**



A further cause for complaint is the length of consultations. Many patients say they feel the GP is pushed for time and rushes investigation into their condition. This points to a need for a more flexible appointment process that can accommodate longer consultations for those with complex and multiple issues or other needs such as advocacy or language support.

GPs also told the review team that the standard 10 minute consultation was not long enough to deal with complex and multiple issues. Extra time is needed when an interpreter or advocate is involved and this should be planned for. BME patients also place particular emphasis on seeing a GP and may not value the input from other healthcare professionals to the same degree. This can lead to repeat consultations and dysfunctional communication.



*When I was a child... well even 10 to 12 years ago, the doctor would spend some time checking you – taking your temperature, checking your blood pressure, and generally asking you how you were... now we barely get five minutes.*

**Middle-age Pakistani mother, Birmingham**



### Case study

#### Making time

One practice visited by the review team automatically booked double appointment slots where the consultation was to involve an interpreter. Another created more flexible time slots for patients who needed extra time. A third practice had developed a way of identifying patients with complex, ill-defined needs who book frequent consultations, and putting in place extra advocacy/language support so that GPs and nurses could deal with issues in a proactive and positive way.

Some BME patients rely on other family members to make appointments on their behalf, adding another layer to the booking process.

They can also be reluctant to accept telephone consultations or to see a nurse instead of a GP.



*My husband calls to make appointments for me. If he can't get through on the phone then he goes to the surgery to make appointments. I have never tried to make an appointment myself.*

**Older Bangladeshi woman, London**



More needs to be done to design appointment systems and services that are easy to understand and navigate and which support the specific needs of local people.

## 5. Quality of general practice

The GP patient survey found wide variations in patient experience between practices, even within the same localities. Our investigations indicate one reason for this is that the quality of general practice is subject to variation – both the quality of the individual GP consultation and the quality of the practice organisation.

Many practices strive to provide a high-quality service for their patients, including BME patients, and have tried a number of different approaches with mixed levels of success. They are working in demanding circumstances and are trying hard to sustain a service in the face of sometimes overwhelming problems. Quality is an issue that GPs must take responsibility for because, as leaders of their practices, they set the culture and ambition.

Spreading the best of general practice everywhere would lead to a significant rise in patient satisfaction.

For their part, PCTs need the right tools to challenge areas of under-performance and to work with practices to ensure they are meeting patients' needs rather than simply fulfilling their basic contractual requirements. PCTs need to have and use the right balance of levers and incentives to challenge poor performance and reward good practice.

The move towards WCC should help address these concerns. WCC will strengthen PCTs as commissioners and develop their skills in tackling variations in performance. For example, their skills in collecting information, benchmarking performance and providing targeted help and support on areas of weakness will be enhanced. In addition, practices themselves need more support from PCTs in order to improve, with particular focus on the quality of practice management. Further suggestions for this are found in the NIT report<sup>16</sup>.

16 Department of Health. Report of the National Improvement Team for Primary Care Access and Responsiveness. February 2008

17 M. A. Stewart Effective physician-patient communication and health outcomes: a review. *Can Med Assoc J.* 1995;152:1423–33

18 Kai J, Beavan J, Faull C, Dodson L, Gill P, et al. (2007) Professional Uncertainty and Disempowerment Responding to Ethnic Diversity in Health Care: A Qualitative Study. *PLoS Med* 4(11): e323 doi:10.1371/journal.pmed.0040323

19 Neal RD, Ali N, Atkin K, Allgar VL, Ali S, Coleman T. Communication between South Asian patients and GPs: comparative study using the Roter Interactional Analysis System. *Br J Gen Pract.* 2006;56:869-75

20 Bischoff A, Perneger TV, Bovier PA, et al. Improving communication between physicians and patients who speak a foreign language. *Br J Gen Pract* 2003; 53: 541–546

21 Harmsen H, Bernsen R, Meeuwesen L, et al. The effect of educational intervention on intercultural communication: results of a randomised controlled trial. *Br J Gen Pract* 2005; 55: 343–350

22 Baker R, Freeman G, Boulton M, et al. Continuity of Care: patients' and carers' views and choices in their use of primary care services London: National Co-ordinating Centre for NHS Service Delivery and Organisation (SDO), 2006, [www.sdo.lshtm.ac.uk/files/project/13b-final-report.pdf](http://www.sdo.lshtm.ac.uk/files/project/13b-final-report.pdf) [accessed July 2007]

23 Mercer, WS, Fitzpatrick B, Gourlay G, Voit G, McConnachie A, Watt GM. More time for complex consultations in a high-deprivation practice is associated with increased patient enablement. *Br J Gen Pract* 2007; 57:960-66

## 6. Continuity of care and the doctor-patient relationship

There is strong evidence to show effective communication between a doctor and patient improves health outcomes<sup>17</sup>. Worryingly, evidence also suggests BME patients tend to experience poorer quality clinical communication than non-BME patients<sup>4</sup>.

The review team found a repeated cause of dissatisfaction was dysfunctional communication between GPs and patients. This is a generic issue applicable to both BME and non BME groups, but language differences can compound difficulties, with implications for patient safety<sup>11</sup>.

Healthcare professionals can feel uncertain<sup>18</sup> and apprehensive in responding to different needs of BME patients and this can cause them to be 'hesitant and professionally disempowered'. One study<sup>19</sup> showed GPs spent less time giving information to South Asian patients even though the patients were fluent in English. While the reason for this isn't known, the study demonstrates the presence of complex and subtle influences on communication. Dedicated training and education for doctors can improve communication with BME people<sup>20 21</sup>.

BME patients are also likely to value continuity of care and the doctor-patient relationship, but find continuity difficult to come by<sup>22</sup>.

Where consultations are longer and there is a strong continuous relationship between doctor and patient, work on health promotion, self-care and modifying health-seeking behaviour is more productive.

Commissioners should place a higher priority on continuity of care and encompass a broader definition of access to include personal care.

BME people can also place too much emphasis on access to a GP and undervalue input from a nurse or other healthcare professional. This can be addressed through education and careful explanation of the valuable role of the multi-disciplinary primary healthcare team. It is important that in widening the range of skills and practitioners provided, practice teams keep a keen focus on co-ordination and continuity of care.

A flexible appointment system that can accommodate 15 minute consultations where necessary can go a long way towards addressing health inequalities. Spending more time with patients in deprived areas improves outcomes and enables patients to take more care of themselves<sup>23</sup>.

## 7. Importance of receptionists

Patients assess their experience from the first contact with a practice and the receptionist plays a major part in whether that experience is positive or negative. For many patients, including many of the BME patients we spoke to, their relationship with the practice receptionist is of pivotal importance. This can extend to a belief that it is harder to get an appointment if the relationship is not good.

The role of 'gate-keeper' is difficult and demanding for receptionists and is frequently a source of conflict.

Some of the best practices and PCTs have helped their receptionists meet the challenges of the role by investing in 'customer care' training designed to increase their skills in acting as practice gate-keepers and helping patients navigate their way through primary care services.

All practice staff should demonstrate high-level customer care skills during all their contacts with patients to ensure patients are treated with politeness and dignity. There is a need for the receptionist role to evolve into that of 'gate opener' and 'patient navigator'.

With better training, reception staff can be empowered to facilitate access by giving information, liaising with bilingual services as appropriate, dealing with patient preferences (for example, the gender of a healthcare professional) and collecting appropriate ethnicity data in a sensitive manner.

## 8. Worse health status

BME people are more likely than non BME people to report that they are in poor health and to seek professional advice for self-limiting illnesses such as colds, diarrhoea and sickness. BME groups are not homogenous and the majority of research is based on South Asian and African-Caribbean populations, but there are consistent findings of a higher incidence of some conditions in one or more BME groups<sup>24</sup>. These conditions include:

- infectious diseases including tuberculosis and malaria
- diabetes mellitus
- coronary heart disease (CHD)
- higher perinatal mortality
- hypertension and cerebrovascular disease
- cancer of the oropharynx, liver and prostate
- haemoglobinopathies
- vitamin D deficiency.

24 Balarajan R. Ethnic differences in mortality from ischaemic heart disease and cerebrovascular disease in England and Wales. *BMJ* 1991;9:560-4

25 Saxena S, Misra T, Car J, et al. Systematic review of primary health care interventions to improve diabetes outcomes in minority ethnic groups. *J Ambul Care Manage* 2007; 30: 218-230

Practices that we spoke to felt it was often difficult to get BME patients involved in traditional preventative health and self-care programmes. There is therefore a clear need to develop more self-care programmes that target the specific needs of BME patients and are delivered in innovative ways, for example, the use of community health educators and link workers in heart disease and diabetes<sup>25</sup>.

### Case study

#### Project Dil

Project Dil was a multi-agency initiative aimed at addressing the high rate of heart disease among the South Asian population in Leicestershire (Dil is Hindi for heart). The project trained members of the public to work as peer educators to carry out health promotion work. It was undertaken from 1999 to 2002 as a formal project. The peer educators were subsequently employed by Leicester City PCT on a consultancy basis. As well as continuing their role of increasing CHD awareness among the South Asian community, selected educators have undertaken further training in order to carry out health promotion work on chronic kidney disease and cardiac rehabilitation. There are now plans to extend the work of the educators to new communities in Leicester.

## 9. Impact of wider issues on health

Social issues such as housing, unemployment, racism, education and literacy can have a substantial impact both on the health of patients and their ability to focus on their specific health needs. Conversely, health issues may add to social problems. For example, Bengali children are often badly nourished and this can lead to underachievement in school, compounding existing inequalities.

These social determinants of health must be recognised by providers and commissioners. Poorer access to primary care should be seen as a broader issue of exclusion and health inequalities. Joint working with other agencies is therefore crucial in enabling community development and cohesion and tackling exclusion.

PCTs in areas of high deprivation need to work with their local authorities through local strategic partnerships (LSPs) and local area agreements (LAAs) to tackle wider social issues impacting on health and well-being. This could entail holistic and innovative approaches to regeneration.



*In Asian areas, there is more crime, more unemployment and fewer health facilities. I think all the Asian areas have the poorly functioning services.*

**Young Pakistani man, Birmingham**



<sup>26</sup> Aswani K. Primary Care. In *New Perspectives in Public Health*. Griffiths S and Hunter D (Eds). Radcliffe. Oxon Second Edition 2007

## 10. Poor NHS links with local communities

There is a large body of evidence that suggests strong partnerships between healthcare providers, local authorities and communities greatly improves access to primary care for ethnic minority groups.

If PCTs are to provide effective, appropriate primary care services, they first have to understand local needs. Having a vision for both public health and primary care is essential. There are several examples of primary care services taking the lead in improving the health of their local population<sup>26</sup>. Strengthening the public health function of PCTs and embedding it in practices is critical.

PCTs should consider BME issues when commissioning and developing new services and health centres. The new services should be sited in areas identified as having the greatest need.

Collecting data on ethnicity is an important part of building the local picture, but it is not enough in itself. PCTs and practices need to improve their links with local communities so that they can better inform BME patients about the services available and how they can engage with them.

Practices should consider setting up patients' groups so that they can listen to and learn from patients.

### *Case study*

#### **Bromley By Bow Health Centre, London**

Bromley By Bow Health Centre is a healthy living centre that provides holistic care using a multi-agency and community engagement model. It routinely records the ethnicity and first language of all new patients. This information not only helps the practice identify services that patients may require during consultation, for example, an interpreter or advocacy support, but also acts as a prompt to the receptionist booking the appointment. The number of appointments lost through lack of language support has been significantly reduced as a result.

### *Case study*

#### **Radio Ramadan**

Radio Ramadan and Asian satellite channels are being used to raise awareness of health issues. The broadcasts target BME groups and provide information that they may have had difficulty accessing through traditional routes.

## What are we trying to achieve?

Our vision is one of a personalised, effective, fair and safe primary healthcare system that is focused on improving the health of local populations by addressing their specific and differing needs.

The advisory board for the NHS Next Stage Review primary and community care strategy will use this report and other sources to help develop a strategy that brings together access issues with other important factors affecting primary care services and the tailoring of services to individual needs.

This review has reinforced the case for looking at how to allocate resources more fairly and in a way that incentivises practices to improve services, as well as how to do more to promote joint commissioning of public services.

## What more needs to be done?

Each of the factors described above poses some degree of challenge or difficulty for patients, practices and PCTs. It will take leadership, responsibility and commitment to address them.

PCTs must take responsibility for providing accessible primary care services that are responsive to the needs of their local populations. This includes providing additional services, where needed, for the benefit of BME patients.

There is an absence of high quality data relating to BME groups that could be used to inform commissioning decisions, yet data is fundamental to the development of personalised, accessible and responsive services for BME groups.

This section sets out a framework for action and subsequent pages set out our recommendations for how the DH, SHAs, PCTs and practices can work to improve satisfaction with primary care services among BME patients, focusing specifically on what can be done to demonstrate the good practice that already exists.

## Framework for action

The approach to solving this problem is based on the five elements of 'CLEAR'.

### Framework for action: A CLEAR MESSAGE

Top five take home messages for PCT Chairs, Chief Executives, PECs and PBC consortia

**C**ommission equitably for a diverse population

**L**eadership: ramp up the profile of the issues in local health economies and identify leaders who will make it happen

**E**ngage, enable and empower citizens through literacy and shared decision-making. Be on the side of' patients and agree rights and responsibilities

**A**dvance the quality of care through practice accreditation and robust GP appraisal

**R**ecord ethnicity data and monitor progress towards equality and quality of care

## What needs to be done

### *By practices*

- 1 Use examples of good practice to deliver high quality care for BME patients.

Practices should use the examples of good practice found in this report to deliver high quality care for BME patients and strive to provide a personalised, accessible and responsive service to all their patients. Where possible practices should work to create a balanced skill and gender mix and discuss what this can (and cannot) deliver with their patients so that they are more informed and feel happier with the choices available to them.

- 2 Work more closely and collaboratively with the PCT to ensure BME patients have excellent access to services that respond to their needs.

Practices should also work more closely and collaboratively with their PCTs through PBC to ensure BME patients have excellent access to services that respond to their needs.

- 3 Work with patients to establish patient partnership groups and forge positive relationships.

Strong relationships between patients and the practice are beneficial for both parties. Practices should use the examples contained within this report and elsewhere and act to reach into the local community. Further information about patient participation groups can be found at <http://www.napp.org.uk/>

- 4 Collect data as indicated in the national minimum ethnicity dataset.

The DH will be working to lead development of this dataset (see recommendation 14). Practices should make use of this, using the information to assess and respond to the experiences and needs of their patients.

- 5 Exercise leadership and commitment to provide a tailored and flexible appointment system with sufficient capacity to be responsive to patients' needs.

Practices need to ensure their supply of appointments matches demand and they should develop appropriate systems to measure this.

### *By PCTs*

- 6 Work to develop competencies as world class commissioners to ensure equitable commissioning of primary care, including establishing programmes of citizen engagement and health literacy.

The WCC programme is designed to move the emphasis from spending on diagnosis and treatment to investment in prevention and health promotion. It recognises the importance of PCTs and their role in planning, developing and monitoring services.

To attain world class status PCTs will have to show better health and well-being outcomes for local people, provide patients with more choice and influence over services and dramatically reduce health inequalities. Commissioning excellent primary care will be a key task for PCTs.

PCTs' success will be measured by a new assurance system that will reward commissioners as they move towards world class standards. PCTs are already working to develop WCC competencies. These will include carrying out joint strategic needs assessments with local authorities. Joint commissioning with local authorities can also be helpful in, for example, providing English courses or a professional interpreter service to improve communications between healthcare organisations and BME patients.

PCTs will also need to work closely with GP practices to develop services that have the most positive impact on patient satisfaction and well-being. They will have to monitor the outcomes of services they develop and tackle persistent poor performance.

Information on performance, collected at practice level (as recommended by the NIT) will not only help PCTs manage differences in performance from one practice to another, but could also help encourage the sharing and embedding of good practice.

Engaging patients and communities is a crucial strand of WCC and each PCT and PBC consortia will need to develop its own programme based on local circumstances. PCTs also need to ensure they talk to patients about services and act on what they are told. A 'rights and responsibilities' framework may also be useful in some circumstances.

A key element of this is health literacy. PCTs should consider establishing a local information hub with a single point of access, using community health guides, leaders or advisers to support patients in making the most appropriate use of NHS facilities and the choices available to them.

The DH is developing a primary care commissioning framework by taking the 11 WCC competencies and translating them for primary care. This will be supported by examples of good commissioning practice from around the country to further support the roll-out and development of good practice.

When procuring health centres and new GP practices, as set out in the interim report on the NHS Next Stage Review, PCTs need to take a view of population need, including BME access issues. Both health centres and new GP practices might be targeted to address long-standing inequalities with a diverse range of services.

PCTs should also do a review of their workforce plans, as in many deprived areas a large number of Asian GPs are approaching retirement. Developing and nurturing a diverse local workforce to meet the needs of communities is crucial<sup>27</sup>.

- 7 Ensure they are fully compliant with the Race Relations (Amendment) Act (2000).

PCTs must ensure they are compliant with the Race Relations (Amendment) Act (2000). The Act places a statutory duty on public services to eliminate racial discrimination and consider the race equality implications of all their policies in all their operations.

- 8 Establish specific initiatives to improve the professional and organisational standards in GP practices.

PECs have a key role to play in developing primary medical services by acting as a driving force for clinical leadership within the PCT and informing the commissioning of externally provided services.

Where PCTs have appointed a full-time medical director, it has provided them with the strong leadership required to drive forward improvements in performance and quality and directly tackle poor clinical and managerial performance within practices.

The GP consultation is a key marker of quality and satisfaction. All GPs should be expected to demonstrate high level skills in communication and consultation with patients. We recommend that NHS appraisal systems should be used to verify their competence in this area according to national standards. This should be a condition for remaining on the PCT performers list, a prerequisite for providing NHS primary medical services.

The quality of GPs is of the utmost importance. We recommend that PCTs consider schemes to support GPs in attaining the MRCGP (*Membership of the Royal College of General Practitioners*) qualification through practice based schemes to continually improve professional standards, particularly in deprived areas.

- 9 Work with practices to develop an appropriate programme for training staff in good 'customer care', including developing 'patient navigators'.

Practices often need additional support in redesigning their systems and services. Training and education can make a significant difference if a sufficient number of professionals have undertaken training at a level to suit their need.

PCTs should work with practices on their patch to develop appropriate training programmes for staff, including training GPs in communication skills, practice managers in organisation and management, receptionists in 'customer care' and developing 'patient navigators' to help patients find their way around local health services.

PBC groups should consider using planned savings to invest in staff training, especially receptionist training, to improve patient experience.

- 10 Analyse the results of patient surveys, including segmentation of the results, and agree action plans with practices to implement any necessary changes.

Those PCTs that are significantly affected by the issues contained in this report must take rapid steps to address the situation. They need to make faster than average improvements in patient satisfaction (as measured by the GP patient survey) and the DH will be targeting support (see recommendation 12) to help them achieve this.

### **By SHAs**

- 11 Provide leadership in primary care and make PCTs accountable for delivering high-quality services.

SHAs should provide leadership by reviewing their understanding of the issues affecting BME patients and their capacity to address them. They should work with PCTs to improve the commissioning of primary care through the assurance of the WCC programme. Finally, they should embrace their performance management role and hold PCTs to account for delivering high-quality primary care services whilst achieving equality of provision.

### **By the DH**

- 12 Support PCTs and practices to implement the recommendations in the report by establishing a national collaborative project.

Practices often need support when they are attempting to redesign their services and systems. PCTs are well placed to provide this support, but sometimes there is a need for more customised and intensive support than even PCTs are able to provide.

In line with the recommendation in the NIT report, the DH should resource a national support team and development programme to help the local NHS implement good practice. One strand of this work should focus on equality. This will target the PCTs with the most profound access challenges, and look to make rapid progress in these areas. Key issues to tackle include developing a commissioning metric for appointments (number of appointments per 1,000 patients), practice redesign strategies, new approaches to patient empowerment, and demand management.

- 13 Strengthen leadership on BME issues.

Promoting a fuller understanding of the issues for BME patients is mainstream business for the NHS. All NHS organisations must ensure there is board level engagement and commitment to achieving equality. It is for boards to decide exactly how they do this. Sometimes when organisations appoint an equality and diversity champion, this can separate the issue from the main business of the board or lead other board members to consider that it is not 'their job'. The review group endorses previous guidance that 'anyone being allocated such a role should be seen as a co-ordinator rather than the sole agent for race equality'.

Leadership on BME issues will also be considered as part of the leadership workstream of the NHS Next Stage Review.

In order to increase NHS awareness about issues for BME patients and highlight current good practice, the DH should organise a national conference on BME primary healthcare by March 2009.

- 14 Promote ethnicity data monitoring in primary care and measure progress towards achieving equality<sup>28</sup>.

Collecting data on ethnicity is an important part of building the local picture. If PCTs are to continue to improve, they will need access to accurate and consistent information about performance and progress.

The DH should therefore lead development of a minimum national dataset covering ethnicity and first language. The data could be collected locally by PCTs and practices who would be able to use it when commissioning services to ensure they meet local needs.

- 15 Ensure compliance by the NHS with the Race Relations (Amendment) Act 2000.

The DH must ensure that SHAs, PCTs and GP practices are compliant with the Race Relations (Amendment) Act (2000). The Act places a statutory duty on public services to eliminate racial discrimination and to consider the race equality implications of all their policies in all their operations.

- 16 Focus on getting the best from general practice everywhere, by working with the RCGP on a quality practice accreditation scheme.

The DH should work with the RCGP on a practice accreditation scheme based on quality standards, patient satisfaction and outcomes for patients.

It should also commission a training module on transcultural communication for primary healthcare professionals. This should be piloted and evaluated. This will support practice teams through dedicated training in cultural competence and generic consultation skills training. The issue of training in transcultural communication is important.

In addition, because of the scale and breadth of issues identified in this report, it would be helpful to have a more in depth thematic review of primary care for BME populations. Subject to legislation, the new healthcare regulator, the Care Quality Commission (CQC), will be operational from April 2009. Once established it will develop new criteria and methodology for assuring and reviewing regulated health and adult social care. We will ask the CQC to consider this specific issue in the course of that work.

<sup>28</sup> Department of Health: Learning difficulties and ethnicity. A framework for action. [www.valuingpeople.gov.uk](http://www.valuingpeople.gov.uk)

## Annex: acknowledgements

### Primary Care Trust visits

All members of the BME Review Group would like to thank the PCTs, practices and individuals who contributed to the report. Without their support this report would not have been possible.

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