Cornwall and Isles of Scilly Primary Care Trust

Health Equity Audit 2008/09

Access to Primary Care for Black and Minority Ethnic Groups and Migrant Workers

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The aim of the report is to present the findings of the health equity audit and to outline the current inequalities that have been found in the access to primary care services for Black and Minority Ethnic communities and migrant workers.

THE HEALTH EQUITY AUDIT CYCLE

Health equity audit is a mechanism to use evidence about health inequalities to inform service planning and delivery. It is a process by which local partners:-

- Systematically review inequalities in the causes of ill health and in access to effective services and their outcomes for a defined population
- Ensure that action required is agreed and incorporated into local plans
- Evaluate the impact of the actions on reducing inequality

Equity audits can enable commissioners and providers of services to ensure that resources are directed towards taking inequalities and can:-

- Inform the commissioning of services
- Contribute to local performance management of public services
- Support partnership working and the allocation of resources
- Encourage community involvement in the NHS and across Local Strategic Partnership planning

The starting point for any health equity audit is a shared understanding of the differences between health inequality and health inequity

Health inequality describes differences in health experience and health outcomes between different population groups according to socio-economic status, geographical area, age, disability, gender or ethnic group.

In contrast, health inequity describes differences in opportunity for different population groups which resulting unequal life chances, access to health services, nutritious food, adequate housing etc. These can lead to health inequalities.

Health Inequalities and Race Equality

The World Health Organisation's defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. (WHO, 1946). 'Health inequality' is the **gap** in health and wellbeing status, in access to health services, between different social classes and ethnic groups and between populations in different geographical areas. Health and life expectancy are linked to social circumstances and childhood poverty.

Overall, the health of our society has been improving for a century or more, the rate of improvement in those from deprived backgrounds has been slower than for those who are better off. Cornwall and the Isles of Scilly have some of the most deprived areas in the country, with some areas having the same deprivation scores as inner city areas of England.

In 2001 the Race Relations Act was amended to give public authorities a new statutory duty to promote race equality: this duty is commonly referred to as the race equality duty. The aim is to help all public sector organisations, authorities and institutions to provide fair and accessible services.

The impact of poor health and the risk of an early death are not evenly distributed across the population. Generally, there are strong links between poverty, poorer health and well-being. Earlier deaths and illness amongst those with the least education, unemployed, in manual or routine jobs and living in an area of deprivation. It is essential to understand the underlying cause of the variations, to target the reducing resources and efforts more effectively. To achieve this, partners must work together to take account of our race equality duty and the role of housing, environment, income, employment, poverty and transport to improve health and well being.

Marmot Review of Health Inequalities

The Marmot Strategic Review of Health Inequalities in England post-2010 was published in 2010. The report states that addressing health inequalities is essential on many levels and that there are economic reasons for doing so. The recommendations of the Marmot Review, are recognised as good practice in addressing inequalities and are incorporated here. Funding needs to be moved, to focus on areas of greatest need first, but it suggests that there should be a proportionate funding that does not focus on just the most deprived.

The findings of the report fit in with the agenda of QIPP (Quality, innovation, productivity and prevention). Many of the ten themes which the McKinsey analysis puts forward as the most effective way to deliver the QIPP agenda are directly related to addressing health inequalities. The challenge remains to show savings in three years or less. The Marmot Review also supports the Commissioning for Quality and Innovation (CQUIN) programme to improve service delivery through whole system approach and quality outcomes for patients and the well being of employees.

Health inequalities will only be reduced effectively through partnership working and a consideration of the wider determinants of health, rather than purely by the NHS. This, combined with the need to be cost-effective and focus on prevention, means that new approaches to delivering public services must be considered and adopted.

Ethnicity & Equality Act 2010

The Equality Act 2010 is a new cross-cutting legislative framework to protect the rights of individuals and advance equality of opportunity for all; to update, simplify and strengthen the previous legislation; and to protect individuals from unfair treatment and promotes a fair and more equal society. 90% of the Equality Act 2010 came into force in October 2010, although the introduction of the socio-economic duty on public bodies remained under consideration.

Ethnicity is one factor on the spectrum of inequality. Some inequalities constitute inequity, that is, they are unfair and not accounted for by a difference in need. Ethnicity is multi-dimensional and usually encompasses one or more of the following:-

'shared origins or social background; shared cultures 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.'

Ethnic group has been measured by skin colour, country of birth, name analysis, family origin and as self identified on the census question on ethnic group. All these methods are problematic, but it is accepted that the self-determined census question on ethnic group overcomes a number of conceptual limitations. For local ethnic monitoring it is good practice to collect a range of information such as religion and languages spoken (Kai J *et al* 1999).

DEMOGRAPHY OF CORNWALL AND ISLES OF SCILLY (updated from refreshed Cornwall and Isles of Scilly Inequalities Strategy and Data Quality report September 2010)

The total population of Cornwall & the Isles of Scilly is approximately 539,100. The 2001 census shows that 4.4% of the population of Cornwall and Isles of Scilly are from backgrounds other than 'White British' compared with 14.7% of the population of England as a whole. Estimates for 2005 show a slight increase to 4.8% for Cornwall and Isles of Scilly and 15.3% for England .

Population Percentages by ethnic group for 2005 ONS (Estimated in 2007)

		England	Cornwall & IoS
White:	White: British	84.7%	95.2%
	White: Irish	1.2%	0.5%
	White: Other White	3.2%	2.0%
Mixed:	Mixed: White and Black Caribbean	0.5%	0.2%
	Mixed: White and Black African	0.2%	0.1%
	Mixed: White and Asian	0.5%	0.2%
	Mixed: Other Mixed	0.4%	0.2%
Asian or Asian British:	Asian or Asian British: Indian	2.4%	0.3%
	Asian or Asian British: Pakistani	1.6%	0.2%
	Asian or Asian British: Bangladeshi	0.6%	0.1%
	Asian or Asian British: Other Asian	0.6%	0.1%
Black or Black British:	Black or Black British: Black Caribbean	1.2%	0.2%
	Black or Black British: Black African	1.3%	0.2%
	Black or Black British: Other Black	0.2%	0.1%
Chinese or other ethnic group:	Chinese or Other Ethnic Group: Chinese	0.7%	0.2%
	Chinese or Other Ethnic Group: Other	0.6%	0.2%

The numbers estimated by the ONS show a rise in minority groups (not including 'White:Irish' and 'White: Other White') in Cornwall and Isles of Scilly from about 5,000 in 2001 to 12,000 in 2005 making up 2.3% of the population.

It is the 'Asian' or 'Asian British' which, having experienced the largest estimated percentage increases of the ethnic minority groups between 2001 and 2005 has the largest population of the ethnic minority groups at an estimated 3,800 people. This makes up 0.7% of the total population of Cornwall and Isles of Scilly in 2005. All other ethnic groups have also experienced increases in population between 2001 and 2005.

The white ethnic groups include 'White British', 'White Irish' and 'Other White' (which includes many of those who identify themselves as Portuguese, Lithuanian, Latvian, Russian and Polish). In 2005, the 'White British' group had decreased as a proportion of the total

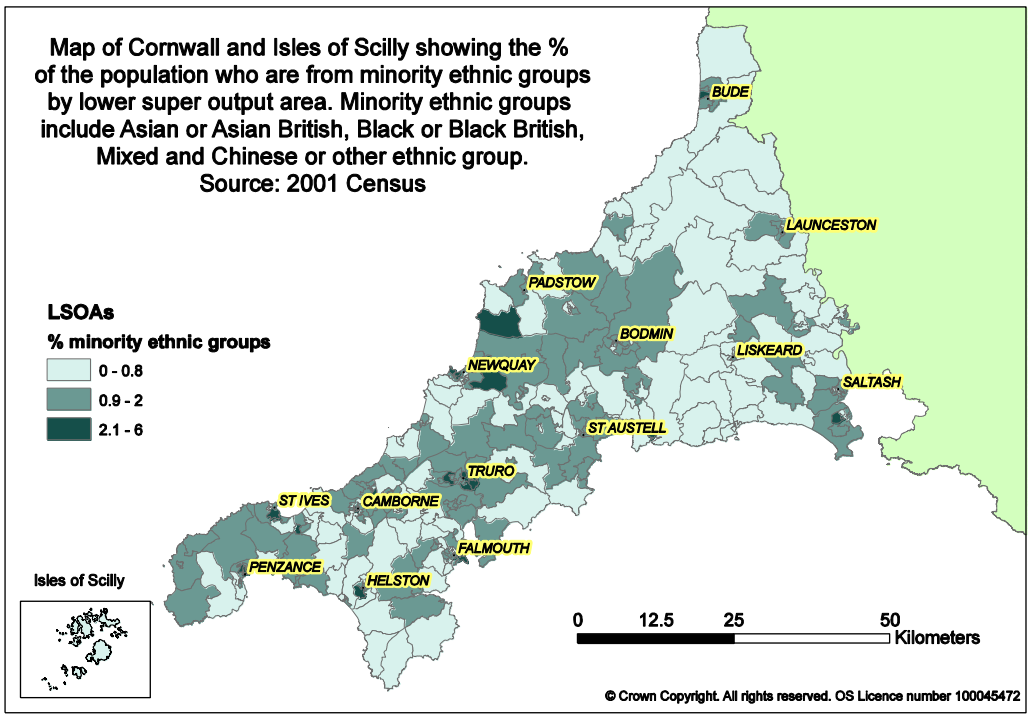
population to 95.2%. However, 'White Irish' and 'Other White' had both increased as a proportion of the total population together making up 2.5% of the population.

The age of the ethnic minority population is generally younger than the total population especially for the 'Mixed' ethnic group of which 50% were under 16 years of age (about 1,500 young people) compared to 18% of the white population. This is similar to the English population. The Office for National Statistics (ONS) estimate for 2005 shows that 24% of the white population in Cornwall and Isles of Scilly and 20% in England are of retirement age. However, for the ethnic minority population groups the percentage is lower; 7% of the total ethnic population in both Cornwall and in England are of retirement age.

Comparing employment for those from a BME with the population as a whole shows a similar pattern of employment in the two populations except for the larger percentage in the ethnic minority population who are full time students and a slightly higher percentage who have never worked. Around Truro there are a larger numbers of higher managerial professionals (19%) and students (24%). It is important we ensure good access to services for this group including awareness of particular health risks for different ethnic groups and signposting which includes translation services where appropriate.

The map below shows where the ethnic minority populations live in Cornwall and the Isles of Scilly. The map uses 2001 Census data as this is the most recent data available at small area geography and this, with the ONS estimates of an increase in the minority ethnic population, should be taken into account. The majority of people live in the towns as would be the case for a map showing the total population. However, in general, groups of minority ethnic residents are dispersed across the County, and this can lead to a sense of isolation and vulnerability.

Minority Ethnic groups



The table illustrates the top 10 Lower Super Output Areas (LSOA) in Cornwall in descending order of the number of people from minority ethnic groups.

Table 1

District	LSOA	Number of people in minority ethnic groups	Percentage of population who are of a minority ethnic group
Carrick	Gloweth and Treliske	94	5.9%
Carrick	Falmouth Arwenack Ward North East	62	3.8%
Carrick	Truro Boscawen Ward South East	55	4.3%
Carrick	Truro Tregolls Ward North	50	2.5%
Penwith	Penzance Central Ward East	48	2.3%
Restormel	Newquay Gannel Ward North East	45	2.8%
Carrick	Falmouth Arwenack Ward North West	43	2.8%
Carrick	Falmouth Arwenack Ward South East	41	2.8%
Kerrier	Helston South Ward West	39	2.5%
Carrick	Truro Tregolls Ward South	38	2.5%

Gypsies and Travellers
For the purpose of this report, the term 'Gypsies and Travellers' used is defined as:-

'Persons of a nomadic habit of life whatever their race or origin, including such persons who on grounds of their family's or dependents' educational or health needs or old age have ceased to travel temporarily or permanently, but excluding members of an organised group of travelling show people or circus people travelling together as such.'

Gypsies and Travellers are some of the most vulnerable and marginalised groups in Britain. They are legally recognised as distinct ethnic groups and have the protection of the law which comes from that. The Race Relations Act identifies each as having a shared culture, language and beliefs.

The County's Race Equality Scheme (2006) reports that the there are between 850-900 Roma Gypsies and Travellers of Irish Heritage in Cornwall and that Roma Gypsies are the largest minority ethnic group in Cornwall.

Regionally and nationally the number of Gypsies and Travellers has been growing. In Cornwall there has been an increase of 13% in caravan numbers between 2003 and 2005, largely on unauthorised sites. Cornwall has a lower proportion of private sites than elsewhere in the South West and the rest of England, and a higher proportion of unauthorised encampments.

There are 28 private and authorised sites including 3 Cornwall Council sites (Wheal Jewel, Boscarn Park and Foredown) & 17 unauthorised sites. The sites lie predominantly in west Cornwall and mid-Cornwalll with none in the far-west or north-east Cornwall. The largest development is at Minorca Lane in Bugle with 586 residents, with the majority thought to be economic migrants rather than Gypsies and Travellers.

In Cornwall, as of April 2009, there are

117 caravans unauthorised on land owned by Gypsies

50 caravans on land not owned by Gypsies
79 socially rented caravans
29 private caravans on authorised sites

Some Gypsies and Travellers also choose to settle into permanent housing.

Migrant workers / economic migrants
Though Migrant Workers have long been a feature of the UK economy, the issue has come into focus with the accession of 8 countries into the European Union from eastern and central Europe in 2004.

Migrant workers are defined as

'those people, born outside the U.K., who have come to the U.K. within the last five years, specifically to find or take up work (including both manual and professional), whether intending to remain permanently or temporarily and regardless of whether documented or undocumented.' (Working Lives Research Institute)

Migrant workers come to Cornwall for a number of reasons. It may be because they cannot find work or progress in a career in their own country, they may be escaping personal issues or be unemployable in their own country. There is a substantial economic crisis currently in the Baltic countries.

The Workers Registration Scheme (WRS) was introduced in 2004 and only applies to those from the Accession 8 Countries. WRS applications in Cornwall have tended to be concentrated in West Cornwall with over 40% working in agriculture and a further 25% in manufacturing. Over 50% of WRS applications are from Polish workers and a further 27% are Lithuanian (WRS registrations May 2004 – March 2006, Home Office).

Not all employers or workers are aware of the legislation and therefore many workers may not be registered. Many casual workers may not work for a single employer for longer than a month. Workers may not register for a number of reasons including the fact that it costs £70 to do so. Research has shown that for every 100 registered workers, there are possibly between 50 and 200 unregistered workers. Those registered on the WRS do not inform the Home Office when they leave employment, except to re-register with a different UK employer (Home Office Correspondence, 2006). It is possible that an employee can register with an employer elsewhere in the UK and then move to Cornwall with the same employer and not appear on Cornwall statistics.

Numbers of migrant workers are fairly steady in Cornwall and are consistent with the LINC estimates (2006) that there are anywhere between 8,000 – 13,000 Migrant Workers in the county at any one time. In terms of nationalities, Polish and Lithuanian are the most numerous. Managers from General Practices have reported that increasingly migrant workers are accompanied by their families.

Agriculture dominates the employment sectors accounting for two-fifths of applications, followed by manufacturing (28.5%) and leisure (20.7%). Most of the businesses that participated in the Migrant Workers Research (LINC 2006) operated throughout the year though some had seasonal peak periods for demand in labour. Migrant workers made up about a third of the workforce of participating companies, most of who were employed directly by the companies. Over half of migrant workers were employed on a permanent basis with a quarter employed on a seasonal basis. Most migrant workers were employed for either the whole year or ten months plus.

Common Languages spoken are Polish, Russian, Lithuanian and Latvian. It is mainly the younger migrants since the separation of Russia that speak Lithuanian or Latvian, but that is only a small percentage of migrant workers.

Amber Initiatives is a non- for- profit organisation, working from offices in Liskeard, Redruth and St Austell. Its objective is to provide assistance to migrant workers in the UK or those who intend to work in the UK. During the month of January 2009 they had contact with 300 migrant workers in Cornwall. The majority of the migrant workers spoke eastern European languages.

HEALTH NEEDS

The health status and health needs of Black and Minority Ethnic (BME) people vary due to the interaction of a number of factors, with some people experiencing better health and some worse health than the UK population as a whole.

These factors include a genetic predisposition to particular illnesses, the impact of culture on individual behaviour, greater exposure to risk factors from their country of origin and differences in educational attainment and in socio-economic status. Social exclusion and low socioeconomic status have by far the greatest adverse impact on population health and so racial discrimination can affect the health of BME people indirectly through lack of employment opportunities, lack of career progression and poor living and working conditions. Racial discrimination can also have a directly adverse impact on both physical and mental health via racial harassment and racial attacks.

Black and Minority Ethnic communities

Some BME people experience poorer health and have unequal access to health services than the general population. Diabetes, coronary heart disease, hypertension, stroke and osteoporosis are more common in some BME groups. National survey results show higher consultation rates for respiratory diseases, particularly asthma, among the Asian population and to a lesser extent African-Caribbean populations. The overall rates of cancer are lower in non-European ethnic groups. However there is some evidence that rates in these groups living in the UK generally are increasing towards that of the whole population possibly due to changes in exposure to risk factors such as diet and smoking. The rates of lung cancer in Asian and African-Caribbean men are increasing predominantly due to smoking. Higher rates of other cancers of the head and neck are seen in Asians and African-Caribbean communities but lower rates of cancers of stomach, colon, bladder, ovary and uterus. Some people who come from countries with a high prevalence of Hepatitis B carriers have a higher risk of developing liver cancer.

Key health issues for BME children are Sickle Cell disease and Thalassaemia, which are higher in people from the African sub continent and some Mediterranean countries. Immunisation uptake rates are usually higher in ethnic minority groups when they have access to a GP or health visitor. Haemophillis Influenza Type B (HIB) infection is significantly more common in Black and Asian people. Hepatitis B infection is also more common in South Asian children.

Black African groups are disproportionately affected by HIV and AIDS and the national picture shows that many sexually transmitted infections are more common in certain BME groups. However teenage pregnancies are lower in many BME communities.

There is limited data nationally and anecdotal evidence showing that drug and alcohol use is evident in BME communities and that a range of drugs are used. Data indicates that overall, drug and alcohol use is more widespread among the white population than any other ethnic group.

The hospital admission rate for mental illness in the ethnic minority population is on average 9% higher than for the UK population as a whole. The highest rates are found in Irish communities and the next highest in people from the Caribbean. South Asians have lower than average admission rates. There is much controversy over the reasons for these differences but no doubt relatively high levels of socio-economic deprivation, cultural attitudes and biological/genetic difference all play a part. Also different types of mental illness are reflected within the different ethnic groups. Among African-Caribbean young men for example, a diagnosis of schizophrenia is 3-6 times more frequent than in the whole population but there are potential issues here around diagnosis bias. Also studies involving Asian people have not always given consistent results but there does seem to be a consistently higher suicide rate among young Asian women.

Smoking prevalence varies across different segments of the population. Whilst rates are now similar among men and women in the general population, they vary markedly by gender across minority ethnic groups. Aspinall (2007) in his report for the London Health Observatory identified that Bangladeshi and Irish men are more likely to report smoking cigarettes than men in the general population, and Indian men less so. Smoking prevalence is higher among women in the general population than most minority ethnic groups (except Irish and Black Caribbean women). Moreover, while the proportion of cigarette smokers fell in the general population between 1999-2004 (from 27% to 24% for men and 27% to 23% for women), changes in smoking prevalence across minority ethnic groups showed no consistent pattern. Whilst smoking levels fell in Black Caribbean men from 35% to 25%, in Irish men from 39% to 30% and Irish women from 33% to 26%, no differences were observed in other minority ethnic groups.

Data highlights that within ethnic groups there are considerable variations in health status and much of that can be explained by differences in socio-economic status. For example not all people from Bangladesh are disadvantaged, even though on average Bangladeshis are poorer than the majority.

Factoring in socio-economic disadvantage, such as low income, does not fully explain the differences in health between ethnic minorities and the majority population. It seems highly likely that other factors, perhaps including the experience of racial discrimination or cultural insensitivity in the provision of health care, are also associated.

Gypsy and Traveller health

The 2004 report on the health status of Gypsies and Travellers in England commissioned by the Department of Health confirmed that Gypsies and Travellers experience health inequality that is even more pronounced than that experienced by other socially deprived or excluded groups or ethnic minorities. They are some of the most vulnerable and marginalised groups in Britain.

Gypsies and Travellers who took part in the 2004 research reported poorer health status over the past year than those in the housed population, and in terms of their health on the day of the questionnaire they had more problems with mobility, self care, undertaking usual activities, pain or discomfort and anxiety or depression.

Health Visitors locally have observed a greater than expected number of colds and minor infections amongst Gypsy and Traveller children compared with the local resident population.

They have noted that children often live in overcrowded conditions and have observed that routine health needs such as the follow-up for asthma and diabetes tend to come secondary to the search for a place to stay. The Health Visitor, in regular work with the community, recognises that the families want childhood immunisations for their children but have a poor understanding of the complex schedules involved. The incidence of bed-wetting (Enuresis) amongst Gypsy and Traveller children has been reported to be higher than average. Health Visitors at the Wheal Jewell and Boscarn Park sites have noticed that children usually drink more carbonated drinks than water due to their travelling lifestyle which limits ready access to water.

Specific illnesses for Gypsy and Traveller adults have been cited such as:-

"problems with their 'nerves', arthritis, asthma, heart disease, chest pain, chronic cough, anxiety and depression" (O'Neill R & Dow M 2002)

Male members of the Gypsy and Traveller community tend not to talk about health issues or seek out health advice and delay reporting illnesses. This often results in the use of Accident and Emergency services due to the severity of illness experienced when they do seek help and the ease of access because of a lack of an appointment system. Evidence suggests a higher rate of miscarriage amongst women and a higher rate of infant mortality.

NHS Cornwall and Isles of Scilly have engaged with Gypsies and Travellers throughout 2010. This work used a questionnaire based survey to assess barriers to health care and their experience of using health care. (See appendix C - 'Extract from Gypsy and Traveller survey – June 2010)

Migrant workers health

There are a number of Migrant Worker communities rather than a single Migrant Worker community, each with their own aspirations and experiences, hence generalising to other groups is not appropriate.

Migrant workers in Cornwall and Isles of Scilly often work in the lowest paid jobs and are likely to experience greater deprivation than the rest of the population. Language barriers amongst other issues means that they are likely to have poorer access to and knowledge of local services than others, find integration more difficult as well as being more prone to exploitation. Media attention has often focused on specific aspects of migrant workers particularly those relating to Gang Masters and the exploitation of workers. However, the topic of migrant workers is characterised by a severe lack of precise data and an abundance of anecdotal evidence.

Interview evidence from Amber Initiative and the Community Development workers suggest that many migrant workers are working below their skill levels even where there are major skill shortages; for many migrant workers pay at, or in some cases below, the National Minimum Wage, is commonplace. Migrant workers are often working long hours and although most do not believe that they are facing conditions that differ greatly from those of the host community, they are often in employment where they are the majority of the workforce.

Experience with accommodation is varied. Amongst Polish workers, early arrivals were largely dependant upon recruitment agencies whilst later arrivals were more involved in finding their own accommodation.

Migrant Worker research (2006) identified 70% of Migrant workers not registered with a GP (this picture differs across Cornwall) and concern of involvement in specific behaviours with health risks. Interview evidence from Amber Initiative suggests that many workers who

require medication do not seek the GP services here but obtain supplies from their home country or they share each others medication. Within certain Eastern European communities it is the cultural norm to drink heavily and detoxification programmes are common.
Many migrant workers have arrived in the UK with tremendous sacrifice to liberty, some with passports and money withheld and coercion demanding sexual favours. Harsh living conditions, poor diet and high levels of smoking and drinking are commonplace.

MORTALITY

Analyses of mortality by country of birth have indicated higher than average mortality among people born in Ireland, Scotland, West Africa, East Africa and South Asia, and lower than average mortality among people born in the Caribbean. Ethnic group is not recorded at death registration, the proxy of country of birth has been used (migrant mortality) when looking at death rates.

The top five causes of mortality in all Black and Minority Ethnic Groups are

- Diseases of the circulatory system
- Neoplasms
- Injury and poisoning
- Endocrine, nutritional and metabolic diseases, and immunity disorders

Sufficient detail on population by country of birth is currently only available at national level (England and Wales) and therefore all analysis of mortality by country of birth is presented at national level only.

People born in Scotland and Ireland have the highest mortality from all causes of death combined and from cancer. People born in Bangladesh and Pakistan have the highest mortality rates from circulatory disease (CHD and stroke). Those born in Ireland, Scotland, India, West and East Africa and the Caribbean Commonwealth also have higher than average rates.

Country of birth has been used as a proxy for ethnicity and many older people born in India for example and living in England and Wales are White. However, studies also show that there is inconsistent reporting of country of birth at death registration and on Census forms which can affect the results, particularly a problem for the Indian subcontinent countries. If country of birth is being used as a proxy for ethnic group it is important to note that the majority of those born in East Africa and resident in the UK, are of Asian origin and those from West Africa of Black African origin.

The inadequacy of country of birth as a proxy for ethnicity demonstrates the need for recording of ethnicity at birth and death registration.

PRIMARY CARE

Primary care describes community based health services that are usually the first and often the only point of contact that patients make with the health service. It covers services provided by family doctors (GPs) community and practice nurses, community therapists (such as physiotherapists and occupational therapists), community pharmacists, dentists, optometrists, midwives and Minor Injury Units.

AUDIT CRITERIA

The concept of equity of access to care has been recognised in national performance frameworks for the health service. In relation to ethnic minorities the key question is whether the uptake of services for specific ethnic groups is higher or lower than would be expected given known differences and similarities in the prevalence of particular health problems.

Equity of access can be described in two ways:-

Vertical equity requires unequal health care to be provided for unequal need; a large proportion of BME people, Gypsies and Travellers and Migrant Workers experience some of the worse health and live in the most deprived communities.

Horizontal equity requires equal health care for equal need.

Equity of access to Primary Care requires that the ethnicity of patients should be recorded at the point of access. High compliance allows comparisons in service use to be made.

CONTEXT

Cornwall has won national recognition for its good practice in supporting and integrating its migrant worker community. Cornwall and Isles of Scilly have a long history of attracting a seasonal worker population within its agricultural population. Cornwall anticipated the effects of the Accession 8 countries by setting up a cross agency Migrant Worker Task force in May 2004 which considers how best to meet the needs of migrant workers in the county. Cornwall's 2006 Migrant Worker Welcome Pack has led good practice in information and advice provision throughout the South West. A new, more comprehensive and updated edition is now available for all workers in Cornwall and the Isles of Scilly.

ETHNICITY MONITORING OF SERVICE ACTIVITY

One of the most basic requirements for monitoring inequality in relation to service use is the ability to record ethnic group along with other activity information. One of the problems with data available is the levels of ethnicity coding being achieved in practice. It is an assumption that access to primary care is poor with very little real data.

The NHS is committed to ensuring that people who speak little or no English, patients whose first language is not English and deaf people receive the support and information they need to access services, are able to communicate with health care staff and make informed decisions about their care and treatment.

Registration

Registration with a GP practice is the route to primary medical care, whether that is delivered by the GP, Practice staff or Primary Care Services. Patients can either register as a resident, temporary resident or for 'urgent and necessary treatment'.

A registration pack is provided by many practices, within which is an ethnicity monitoring form for completion and return to the practice. Not all practices request this information.

Many migrant workers are encouraged to register with their local GP as the generation of a national insurance number is important for obtaining a bank account. Practice managers in the east of the county report that a large proportion of migrant workers are accompanied by a representative of their employer to facilitate registration. A recent survey in West Cornwall (LINC 2007) identified that 71% of migrant workers were not registered with a GP. However

Migrant workers who formed part of a Focus Group had generally registered with a GP, and most people had found this easy to do. Most employers (63.5%) said that they ensured that their migrant workers were registered with a local doctor.

The majority of migrant workers are single or sometimes register as a couple. Practice manager interviews revealed that a few migrant worker children are registered with the practice which requires the translation of child health and vaccination records. Amber Initiatives, through their contact with Migrant Workers, suggest that many workers do not register because they believe that they do not need a GP; they are usually quite fit and may not be in one place long enough to consider registering worthwhile. Many are used to a different style of health care delivery.

A number of GP practices have produced leaflets for people wishing to register with a GP which requests the production of a passport or European Health Insurance card to show entitlement to register. In a sample of leaflets seen there was an expectation that the person would be resident for 3 months or more.

In the last Gypsy and Traveller Accommodation Assessment, conducted in 2006, respondents were asked directly whether they had ever been discriminated against when trying to access services; almost a quarter (23%) said they had. The most common source of discrimination was health services, specifically with problems registering without a permanent address or being told that a travelling lifestyle meant they *'are not local enough'* to register in Cornwall. Three-quarters of respondents were permanently registered with a GP and a further 15% had temporary registration. 82% of those who were registered were with a GP in the area they were living in. Respondents living on sites owned by other landlords were the least likely to be registered. All respondents in bricks and mortar accommodation were registered, as were all respondents living on their own land with planning permission or awaiting a decision. This indicates that GP registration may be linked to security of tenure and having a permanent address for registration.

A comparison of employment groups (JSNA 2008) shows a similar pattern of employment in the BME and White British populations except for a larger percentage in the ethnic minority population who are full time students and a slightly higher percentage who have never worked. The large towns of Truro and Falmouth show a marked difference to the rest of Cornwall. It has larger numbers of people from BME groups in higher managerial professionals (19%) and students (24%). Information from Practice Managers indicate that because of their occupational status, a large number of people from Black and Minority Ethnic groups tend to register with a GP, encouraged by occupational health requirements.

Primary Care are producing a leaflet about registering with a GP which will be translated into a number of languages common to Cornwall and Isles of Scilly.

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) was introduced as part of the new General Medical Services contract in 2004. It was a pioneering approach to improving quality of care through a voluntary incentive scheme rewarding GP practices for how well they care for patients, not just how many patients they have on their list.

GPs have never been obligated to record the ethnicity of their patients. The incentive currently for recording the ethnicity of patients only applies to new patients that register with the practice.

To qualify for the QOF incentive, practices need to have recorded the ethnic origin of all new registrants for the last two years. To achieve this, 100% compliance is required. QOF data for 2008 revealed that 87.7% of new registrants have had their ethnicity recorded but this

ranges from 100% in a large number of practices down to 2.79% in others. This equates to 94,000 of a possible 107,000 new registrants in the last 2 years.

New registrants should receive an ethnicity monitoring form in their registration pack but its completion is voluntary. If the form is not returned within a certain period then the ethnicity status of the applicant may be described as 'not disclosed'. A practice can achieve 100% ethnicity recording for QOF, which will include people in the 'not disclosed' category, but the ethnicity status of all new registrants will not be known.

The accuracy of patient numbers is complicated by the fact that Practices are not always aware when migrant workers move areas for employment or return to their home country unless the records are requested by another practice.

A programme of more complete ethnicity coding of patients was implemented through Clinical Directed Enhanced Services (DES) guidance for 2008/09 which was released in September 2008, which expected practices to record the ethnicity and first language of all practice patients on their list. This government priority was in response to the Black and Minority Ethnic (BME) Access Review (2007). Target payments are attached to achieve 100% recording in two years. The aim of this DES is to enable PCTs and practices to assess the needs of their population and to address inequalities in access and health outcomes for BME patients. This will include children and babies where the ethnicity and first language will be defined by their parent or guardian.

A delayed roll-out from government (intended from April 2008) will make the target difficult to achieve. Payment will only be triggered once the practice has recorded this information for 50% of its patients in the first year and 90% in the second year (as measured on the 31st March each year); not all practices have signed up for this enhanced service. Practice managers indicated that practices have in some cases been reluctant to collect data for existing patients, questioning the benefits of this information to the practice beyond the needs of the individual patient in front of them.

DATA SYSTEMS

Coding

The recording of ethnicity for new registrants has been a condition of QOF with some practices recording for longer. Patients have a right to self classify their ethnicity and do so by completion of the ethnicity monitoring form at the time of registration. This information is voluntary and many chose not to complete this form. Options are currently the 16 code national standard and it is likely that Eastern-European migrant workers and Gypsies & Travellers could self classify as 'white other'. It is not possible from this to differentiate migrant workers from resident populations. Additional codes would need to be considered.

GP data systems - EXETER (NHAIS)

The original Exeter System was created in the late 1970's by a DHSS and IBM funded project to link the records of two Exeter practices with the Royal Devon and Exeter Hospital. The Exeter System, due to so many years continuous refinement, is one of the most dependable software packages available for General Practice. The system has evolved year-on-year to meet the demands of General Practice and of the requirements for accreditation.

The national registration scheme (Exeter) for patients registered with General Practitioner does not have a field to record ethnicity. If the practice records ethnicity on the local system the national monitoring system cannot mirror this.

Practice managers interviewed have identified a limitation to local data systems and are unable to select criteria for ethnicity. Manual trawling of notes and electronic records is the only way to identify patients from Black and Minority Ethnic Groups and this is both crude and speculative by searching for surnames. Search criteria exist for 'history not obtained' which may indicate an absence of UK records and possibly recent registration in the UK but that could include members of the UK armed forces, regardless of ethnicity. Conversely a person with diabetes, for example, may have significant records yet be recently registered from another country. There is no current satisfactory method for practices to identify patients by their self defined ethnicity status. This will change with the National Programme for IT "Connecting for Health"

The National Programme for IT (NPFIT) is introducing an electronic Care Record service for all patients and service users of the NHS. The Care Record service will mean that no matter where an individual approaches the NHS for help, her/his personal and healthcare details may be accessed. The Care Record service comprises two parts – the Personal Demographic Service (PDS) and the Personal Spine Information Service (PSIS).

It is planned that the PDS will collect data on basic demographic details including NHS number, name(s), date of birth, address and postcode, preferred gender, preferred language, communications requirements, contact details, name of GP, need for interpreter and use of Braille.

The PSIS will collect data related to individuals' clinical care. What is recorded on the PSIS will vary depending on the needs and circumstances of individual cases. This can include, amongst others, details of ethnicity, faith and belief.

COGNOS
This is an executive information system that uses front end software to interrogate data cubes comprising of inpatient and out patient data, GP registrations and population data. Although COGNOS slices and interrogates the information, essential ethnicity coding is based on PAS and Exeter. Access to primary care services by ethnicity cannot be described using this system and access to secondary care would need to be interpreted with caution.

QMAS
The Quality Management and Analysis System (QMAS), is a national IT system which gives GP practices and Primary Care Trusts objective evidence and feedback on the quality of care delivered to patients. It supports the Quality and Outcomes Framework (QOF) element of the GP contract and has been in operation since 2004. QMAS shows how well each practice is doing, measured against national QOF achievement targets.

QOF recording for ethnicity for the population of Cornwall and Isles of Scilly varied between 2.79% and 100% for new registrants only in the past two years. Care should be taken in interpreting the quality of information behind this score.

APPOINTMENTS

Contact with practice staff reveal that not all GP receptionists receive equality and diversity training which can improve their ability to help in a positive, culturally sensitive way.

GP registration is very high for Gypsies and Travellers living in permanent accommodation, but lower for those on temporary sites (Cornwall County Council 2006). Further information from the accommodation assessment (2006) identified a low use of support services, with the majority of respondents with health issues relying on extended family and friends for help.

Health Visitor and Practice experience suggests a reliance upon a literate member of the family. Many travellers have difficulty keeping appointments for differing reasons for example not keeping a diary or literacy problems or a sudden eviction (Derby Gypsy Liaison Group 2004). Practice staff as a result experience frequent non-attendance for appointments by some Gypsy and Traveller families. Access to transport is a possible contributor to this with many of the men going off to work early in the only transport available and women remaining on the sites; many women also do not drive. In areas with Gypsy and Traveller communities often the appointments are followed up with a reminder telephone call that morning with a 4-5 hour prompt. Appointments offered at 4pm tend to be more successful than those offered at 10 am.

A patient's proficiency with English and the availability of interpreters contributes to the success of getting appointments for BME people and migrant workers according to Community Development Workers. However, Amber Initiative's experience with migrant workers shows that there are no barriers to accessing the GP. Further discussion revealed that :-

"If migrant workers are here less than 6 months then they tend not to visit the GP. The majority of workers are young, fit and healthy. If their health is in a poor condition then they are more likely to not come to the UK to work long hours but stay at home".

Many surgeries across Cornwall and Isles of Scilly have 'open' appointments which improves accessibility to services for people with long-hours work commitment such as migrant workers and for people who have difficulty keeping appointments such as Gypsies and Travellers. The development of GP led services and extended hours initiatives across Cornwall and Isles of Scilly should improve accessibility to GP services.

EXTENDED OPENING HOURS

Since May 2008, GP practices have been offering additional pre-booked appointments outside of normal working hours. In Cornwall and Isles of Scilly, 97% of practices in the area offer these additional appointments. The appointments are provided either early in the morning, on certain weekday evenings or on Saturday mornings, or even a combination of these options. They are ideal for patients who find it difficult to attend during normal opening hours and are available for any patient to book. One practice in the east of Cornwall, for example, is open until 11pm to cater for shift workers at a local large employer. Many practices across the health community are open until 8pm and open on Saturdays for routine Primary Care services. This is especially useful for migrant workers and BME people working in the restaurant trade and service industry but may not be sufficient for migrant workers in the agricultural industry where transport and access can still be an issue.

KERNOW URGENT CARE SERVICE (KUCS)

Ethnicity is not routinely recorded for patients using the 'out of hours' service KUCS. There is a facility to record this but it is generally not completed. An audit of people requiring 'out of hours' care, by ethnicity is not possible. KUCS have not noticed any significant numbers of people from BME groups or migrant workers using the out of hour's services.

A patient survey is carried out following the conclusion of a treatment episode and there is a facility to record ethnicity. This information is used to update records and if the patient does not speak English then this is recorded. KUCS has noticed more migrant workers using the

service, for example a number of workers from Eastern Europe attended Liskeard 'out of hours' in March 2009 and brought their own translator.

Most of the service users (98%) are registered with a GP. Where language is a potential barrier to offering care, 'language line' is used. However, contrary to PCT policy, in the majority of cases people come with their own translator or a member of the family with a proficient command of English language.

GP LED SERVICES

Supported by a national initiative, Cornwall and Isles of Scilly PCT implemented a GP led service to enable equitable access to medical care, resulting in a new health centre in Redruth – Cardrew Health Centre (see appendix D). The target area for this new service was identified by the high levels of deprivation in the wards of Redruth North and Redruth South and high numbers of migrant workers.

The centre, based on the model of 'NHS walk-in Centres' available in more urban districts has been located to be very accessible by train, bus and road. Its proximity is close to a major road (A30) and train station with numerous bus routes passing the site.

The new service opened in 2009 and is advertised widely including adverts in Polish in the local free papers. The unit is open 8am to 8pm 365 days of the year. Advertising of the centre is further promoted by encouraging its use by local groups such as 'Colourful Women'. Colourful Women is a women's health group which provides an opportunity for women from the many backgrounds and diverse cultures in the county to meet in a safe and friendly atmosphere. The group aims to share experiences, learn new skills, improve knowledge of the English language and keep fit and healthy. The patients are able to walk in without an appointment but will still have to register as a patient. The centre is focussed on language diversity and the needs of BME people. The centre employs a Polish Receptionist (2009).

HEALTH FOR HOMELESS

The Health for Homeless Project is run from clinics based in hostels and day centres in Truro, Camborne and Penzance. People not registered with a GP, whether they are street homeless or living in a caravan, can register with the Project as a temporary resident. The service is flexible and adaptable to the needs of the homeless; people are known to have travelled large distances to access them.

The clinics are not geared up to provide children's services and as such they do not register children under the age of 16, which can be an issue for travelling families. The hostels in which the clinics are based are not appropriate environments for children; although the service is looking into the provision of child health services next year.

The quality of recording of ethnicity could be improved and is dependent upon the clinician seen at the consultation. Ethnicity data supplied for the 12 months of 2008 revealed:-
41 patients (31 male & 10 female) White British
1 patient (male) White & Black Caribbean
1 patient (male) White & Asian

The service is advertised in the Migrant Workers Welcome Pack and has registered some migrant workers; Camborne has a substantial transitory Polish working community.

Two patients out of 43 (4.6%) attended who identify themselves other than White British. Local data cannot tell us what proportion of BME groups and Migrant Workers would classify themselves as homeless and try to access 'homeless health services'. Without this denominator population it is difficult to interpret if access to this service is equitable.

PATIENT SATISFACTION SURVEYS

The last reported national GP patient survey was conducted in 2007/08. It was sent to a random sample of 5 million people in the country registered with a GP. People were selected via the EXETER system supported by each Primary Care Trust. Nearly half of the sample (2.4 million) responded with 35,000 respondents resident in Cornwall and Isles of Scilly.

Criteria measures in this Access and Responsiveness in Primary Care survey (DH 2007) were:-

- Being able to see a GP in 48 hours
- Ease of telephone access
- Being able to pre-book an appointment
- Ability to request a choice of GP

Overall the results showed:

- 86% of respondents were satisfied with telephone access
- 86% of respondents were satisfied with access within 48 hours
- 84 % of respondents were satisfied with the current opening hours
- 75% of respondents were satisfied with advance booking
- 88% of respondents were satisfied with their choice of GP

The survey found that a large proportion of BME patients, particularly Bangladeshi patients, were less happy with access to primary care services than white patients, sometimes even within the same practice.

The survey showed overall that

- 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.

Survey results are available on line by GP practice. However, only one survey question is reported by ethnicity – opening times of the GP practice. This was coded as 'White British' and 'Non-white British'. Results indicated that 82% 'Non-white British' were satisfied with opening times compared with 85% White British.

The results may mask the issues of access, language or literacy, which are challenges experienced by a large number of BME people, Migrant Workers and Gypsies & Travellers who will have had limited opportunity to participate in the survey of the GP registered population.

Factors contributing to responsiveness and accessible primary care for BME groups were further investigated and identified in a separate report led by Professor Mayur Lakhani 'No Patient Left Behind (DH 2008).

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

- A number of BME patients say that they feel unable to complain about primary services and find it difficult to exercise choice by switching practices when they are not satisfied with the service offered.
- 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. Patients can have unrealistic expectations about services.
- The process of making appointments and understanding choices appears to be hard for BME people, particularly where there are communication difficulties. This is frequently a source of conflict between patients and receptionists.
- The GP patient survey fond wide variations in patient experience between practices, even within the same localities. The investigation indicated that the quality of practice is subject to variation.
- The review team found a repeated cause of dissatisfaction was dysfunctional communication between GPs and patients
- The role of 'gate keeper' is difficult and demanding for receptionists and is frequently a source of conflict.
- BME people are more likely to report that they are in poor health and to seek professional advice for self-limiting illnesses such as colds, diarrhoea and sickness.

A more recent survey was conducted January-March 2009. The sample comprised all individuals aged 18+ at the time of sampling who have been registered with the same NHS practice for 6 months. This could exclude those who are temporary residents and those recently registered. Results are expected to be reported in July 2009.

This will be an expanded survey reporting on:

- Aspects of the surgery environment and helpfulness of surgery staff
- Getting through on the phone including for consultations or test results
- Accessing GP appointments (including questions supporting assessment of QOF achievement on 48 hour access and advance booking)
- Waiting time in the surgery
- Seeing a preferred doctor
- Satisfaction with practice opening hours
- Aspects of the consultation with doctors and nurses at the practice
- Overall satisfaction with care received

Expanding the survey questions beyond fast and convenient access to GP appointments will provide a much richer assessment of patients' experiences when they access their local GP service. This addresses patients' concerns over the previous survey that it restricted their say to only narrow definitions of access.

Patients are required to access a website (http://www.gp-patient.co.uk) for support with a detailed Frequently Asked Questions section. These will be available in English and in the 13 other languages most commonly used by NHS Direct. This in itself may affect the response rate from BME people if there are language and/or literacy problems.

It would be useful if on-line results could give all the success criteria by ethnicity and not contained to one element. Also a breakdown of respondents by ethnicity would give an indication of the breadth of the survey. Both these elements would increase confidence in the generalisability of the results.

PRIMARY CARE SERVICES

Uptake of breast and cervical cancer screening

The EXETER system, used to monitor coverage for cancer screening does not enable the recording of ethnicity. Enquiries to some of the Cornwall & isles of Scilly General Practices revealed that people who had defaulted from an invitation for screening could be identified as a cohort but a trawl of notes by hand would be needed to identify people from a Black and Minority Ethnic background or who were possibly migrant workers, by surname detection.

Some practices have reported difficulty in engaging with Muslim women to undertake cervical smears. The Health Visitor working with the Gypsy and Traveller families acknowledged a reluctance of some women to comply with invitations for cervical cancer screening. Data does not yet exist to suggest inequality in access to screening services but there may be cultural differences in their acceptability and importance.

Immunisations

The ethnicity of children attending for routine immunisations is not recorded and the current child health data system does not support this.

Seasonal influenza vaccination targets cover the uptake of vaccines in the over 65 age group and those people specifically susceptible to the complications of influenza infection. The proportion of people from BME groups who take up the opportunity for influenza immunisation cannot be determined as the ethnicity of recipients is not recorded.

A new Human Papilloma Virus (HPV) immunisation programme has been implemented for young girls aged 12 to 13 years of age with a catch-up campaign to include girls up to the age of 18 years. The programme is aimed at reducing the incidence of cervical cancer. Although ethnicity can be recorded on the HPV consent forms, the child health system is unable to retain that information. The consent form is scanned into the patients (GP) notes only.

Integrated care systems

All face to face contacts of Primary Care Staff, District Nurses and Health Visitors are recorded on an Integrated Care System. Data for April 2008 to January 2009 reveals that 16% of face to face contacts remain un-coded for ethnicity.

Table 2

Number of face to face contacts split by ethnic group for April 2008 to January 2009

Ethnic Category	Total	Percentage
White British	350108	76.9%
Not stated	48156	10.6%
Not known	25930	5.7%
Any other White Background	16677	3.7%
Blank	10597	2.3%

White Irish	1184	0.3%
Any other ethnic group	424	0.1%
Any other mixed Background	362	0.1%
Mixed White and Asian	350	0.1%
Any other Asian Background	316	0.1%
Mixed White and Black Caribbean	313	0.1%
Mixed White and Black African	231	0.1%
Chinese	204	0.0%
Asian - Asian British Indian	105	0.0%
Any other Black Background	74	0.0%
Black - Black British African	68	0.0%
Black - Black British Caribbean	33	0.0%
Asian - Asian British Bangladeshi	29	0.0%
Asian - Asian British Pakistan	19	0.0%
Total	**455180**	

Compared with the 2007 estimated population profile of Cornwall and Isles of Scilly, there is under representation of all Black and Minority Ethnic Groups. There is a greater proportion of people determined as 'white other' which may indicate engagement with Polish and Lithuanian communities but this cannot be determined on the basis of these figures. The data available suggests that Black and Minority Ethnic people are not engaged in Primary Care Community services but this may be a result of the deficiencies in ethnicity recording. However, the cultural attitudes to health and healthcare use of services both traditional and complementary, and the prevalence of key health conditions in ethnic groups that require community health care support needs to be considered.

Minor Injury Units

Minor Injury Units (MIUs) are provided from 12 sites across Cornwall and Isles of Scilly, often attached to community hospitals. Highly skilled specialist nurses run the units which have access to advice from the Accident and Emergency (A&E) department, as required. These units are able to treat a range of conditions including cuts, bruises, burns, broken bones (where the bone does not protrude through the skin), sprains, strains and head injuries (where the person has not been unconscious).

Three minor injury units were contacted for the audit, St Austell, Newquay and Camborne-Redruth. The units reported that the ethnicity status of patients has been manually recorded on patient's treatment cards for approximately one year but this is not entered onto the MIU data system; there are no fields to record this electronically.

In contrast to when they opened first in 2003, the units report regularly see migrant workers as part of the patient workload, although recently these numbers have declined. One unit reported providing health information and registration cards in Polish and most local patients are already registered with a GP. The more mobile gangs of workers are often not GP registered and the MIU will assist in getting the patients registered by phoning the local surgery and making an appointment for them. Agricultural workers are often more mobile and not registered with a GP whereas those employed by the larger companies such as Roach foods, are mostly registered with a GP and housed locally.

The MIU system is a satellite system drawn from PAS (Patient Administration System) which has recently started recording ethnicity status. There are no system outputs yet to demonstrate equity of access by ethnicity.

Smoking cessation

Measuring equity of access to stop smoking services is important because smoking is the single greatest cause of preventable illness and death in the UK. The targets under the Public Service Agreement (2004) are to reduce adult smoking rates to 21% or less by 2010 and to lower smoking prevalence among routine and manual groups to 26% or less.

The National Institute for Health and Clinical Excellence (NICE) has stated that reducing smoking prevalence among people in routine and manual groups, some minority ethnic groups and disadvantaged communities will help reduce health inequalities more than any other public health measure. The proportion of people who are not smoking after 4 weeks can be indicative of the effectiveness of stop smoking services.

From April 2008 to March 2009 the Cornwall and Isles of Sicilly stop smoking service have seen 123 patients from BME Groups groups. Only two were referred by their GP, the others all self-referred. Thirty-eight BME people had stopped smoking at four weeks; a quit rate of about 31 per cent. This quit rate is below the county average of about 50 per cent.

Current ethnicity profile of smoking cessation clients from April 08 to March 09

Table 3

Ethnic Group	Number attended (number quit)	Ethnicity by proportion	Quit rate (4 weeks)
White British	3911 (2072)	95.5%	53%
Not stated	62 (29)	1.5%	46.8%
Irish	10 (4)	0.2%	40%
Other White	45 (19)	1.1%	42.2%
White/Caribbean	5 (1)	0.1%	20%
White/Black African	4 (0)	0.1%	00
White/Asian	1 (0)	0.02%	00
Other mixed	3 (2)	0.07%	66.7%
Indian	2 (2)	0.05%	100%
Bangladeshi	6 (1)	0.15%	16.7%
Other Asian	3 (1)	0.07%	33.4%
Caribbean	3 (0)	0.07%	00
African	14 (4)	0.3%	28.6%
Other black background	3 (1)	0.07%	33.4%
Chinese	6 (0)	0.15%	00
Other ethnic group	18 (6)	0.4%	33.4%

Proportionally the ‘White British’ group is representative of the population estimates (2007) whilst ‘Irish’ and ‘White Other’ are under represented. There appears to be a lower level of representation from the BME groups amongst attendees at the stop smoking service with the exception of people who describe themselves as Bangladeshi or Black Caribbean. Quit rates are highest for the ‘White British’, ‘Other Mixed’ and ‘Indian’ (although the numbers are very small and should be interpreted with caution).

Local data on smoking rates by ethnicity does not exist but rates are thought to be similar to the national picture. The considerable diversity in smoking prevalence in groups such as Asians makes the data of only limited value in investigation of equity of access and use (Aspinall 2007).

Access to Pharmacy services
Feedback from Amber Initiative and the Community Development Workers suggest that there are instances where language barriers have led to less than clear discussions regarding prescribed and dispensed medication and medication bought 'over the counter'.

It is not clear what proportions of people from BME groups seek advice directly from a pharmacist as the pharmacists do not record the ethnicity of clients in face-to-face consultations.

Access to Dentists
For Gypsies and Travellers registration with dentists was significantly lower than with GPs – just 14% of respondents were registered (Cornwall County Council 2006). Respondents on the local authority sites were the most likely to be registered – just over a fifth (21%) were registered. This is in contrast to respondents living on sites owned by other landlords, where only 10% were registered. The main reason given by respondents was the shortage of NHS dentists in Cornwall. None said their status as Gypsies and Travellers made registering more difficult than for other people

Members of the Newquay Migrant Worker focus group (LINC 2006) said they had not registered with the Dentist, it was too expensive, but they had been told that before coming to the UK.

The Community Dentistry ethnicity profile for the 6 months of 1st April 2008 to 30th September 2008 identified that 99.5% (13072/13089) were White British. White Other comprised 0.4% of the patients which may encompass some migrant workers. There appears to be a lower than expected rate (0.1%) of BME service users suggesting inequity in access for BME people which may not be totally explained by differences in cultural attitudes to health. This represents only 6 month's statistics and should be interpreted with caution.

INTERPRETATION AND TRANSLATION SERVICES

Access to and use of appropriate interpreting services is one of the most important health care needs identified by people from ethnic minorities themselves, for effective communication in health encounters (Yee L 1997, Fasil J 1996). In an estimate of functional English literacy amongst ethnic groups, almost 3 out of 4 of those born outside the UK were below 'survival level' for functional literacy (Carr-Hill R *et al*. 1996), although this figure may well have changed over the years since this publication.

Interpreting is defined as the oral transmission of meaning from one language to another, which is easily understood by the listener. Interpreting can be provided face-to-face or by telephone. Translation is defined as the written transmission of meaning from one language to another, which is easily understood by the reader.

The Interpretation and Translation Service is provided by the PCT for all Primary Care involving contractor services. From the inception of the Patient Advice and Liaison Service (PALS) in 2002, it became apparent that an interpretation and translation service was needed. Initially, the service relied upon dual language speakers, either volunteers or staff working in the hospital. However ethical conflict and sustainability required the service to be outsourced to Language Line and Jobline. Each GP is able to book Language Line directly to assist interpretation during a consultation via a third party over the phone, using their own unique code. The PCT is then recharged via an accountancy agency

Polish was the most popularly requested followed by Lithuanian. Patient information is often translated into Portuguese, Lithuanian and Polish and includes personal health records; immunisation & child health records, for example.

A recent audit identified a higher service use in West of Cornwall which may reflect a greater need for interpretation services or simply a greater demand for the service. There are also a greater number of BME people in the west of the county including Polish migrant workers

Community Development Workers in Cornwall and Isles of Scilly experiences of low staff awareness of the interpretation and translation services in some parts of the County. They revealed that in health care situations, some people still rely on family members to provide an interpretation. Many people do not know that they are entitled to an interpreter and many are under the impression that they need to provide someone who speaks English or change their GP. Examples have been provided at Appendix A.

COMPLAINTS PROCEDURES

The trust complaints procedure exists to improve the quality of services and care offered, which includes timely access to primary care.

The follow-up investigation, reported in the document *No Patient Left Behind* (DH 2008) identified 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. The report urged a need to build trust between BME communities and their local NHS.

Cornwall and the Isles of Scilly Primary Care Trust has a long history of engagement and as an example the Equality Scheme Consultation and Involvement events took place in April and May 2009 at venues across Cornwall and Isles of Scilly.

No complaints have been received by Cornwall and Isles of Scilly Primary Care Trust from members of the public who would identify themselves from a Black or Minority Ethnic background. The 2009 Migrant Workers pack does not include information about the complaints procedure. However the services that people engage with, as a result of using the Migrant Workers Pack should be explicit about their complaints procedure.

Community Development worker opinion is that for BME people the complaints system does not work, echoing the results of the review led by Professor Lakhani. Unity Cornwall and Community Development workers voiced concern that institutions are mistrusted by the Black and Minority Ethnic communities. One route may be the use of Third Party reporting through the Race Equality Council.

PROXY MEASURES

In the absence of robust ethnicity data indicating access to primary care by ethnicity a proxy measure could be used by examining the proportion of people referred to secondary care, indicating successful access to Primary Care.

Primary Care referral patterns
The hospital based GP service at A&E screens referrals from GPs but ethnicity data for these referrals is not recorded.

Patient Administration System (PAS)
The Patient Administration System (PAS) is one of the earliest components of a hospital computer system which records the patient's name, home address, date of birth and each contact with the outpatient department or admission and discharge. Ethnicity recording is most robust for In-patent and Maternity Services. For the last 12 months, ethnicity has been recorded for:-
75% of Outpatients 75% of patients
65% of Accident and Emergency patients
97% of women attending the Maternity Unit
97% of Inpatient admissions

Although high, the quality of recording could be improved and may contain high responses of *'ethnicity not given'*. The recording of ethnicity has been mandatory from 1st April 2009 (DSCN 11/08)

Patients admitted to Hospital
Admitted Patient Activity has been examined for three generic areas: General Medicine; General Surgery and Midwifery

It is assumed that generic medicine, surgery and midwifery hospital services would apply to all ethnic groups, rather than the defined specialities whose use may be greater influenced by ethnic background and associated health risks. Black and minority ethnic groups should be better represented at midwifery services as they are predominantly a younger population and less so with general medicine and surgery where the patient is likely, but not always, to be advancing in years.

Ethnicity is not known for 16% of surgical patients, 12.7% of General medical patients and 2.4% of midwifery patients. An additional code has been introduced to count those who consider themselves to be Cornish. Highest completion rates for ethnicity coding can be seen in Midwifery and the lowest in Surgery.

The number of patients described by ethnicity code other than 'white' are small. Population estimates (2007) identify BME people accounts for 2.3 % of the population. An aggregated count reveals that 0.6% of the surgical beds, 0.4 % of the medical beds and 1.9% of the Midwifery beds are occupied by the patients describing themselves as belonging to a Black or Ethnic Minority Group.

Firm conclusions from this data cannot be drawn. Cultural attitudes to health, prevalence of medical and surgical conditions and the age structure of the population will influence the need for inpatient care. Whilst the recording of ethnicity is better than within Primary Care, it could be improved further for medicine and surgery. It would be useful to identify at what stage in pregnancy women engage with midwifery services and if there is a difference between ethnic groups.

Patients admitted to Hospital by Ethnic Group

Table 4

		General Surgery (proportion)	General Medicine (proportion)	Midwifery (Proportion)
White:	White: British	10159 (75%)	10028 (59%)	3429 (87%)
	White: Irish	41 (0.3%)	41 (0.3%)	10 (0.3%)
	White: Other White	411 (3%)	427 (3.4%)	162 (4.1%)
Mixed:	Mixed: White and Black Caribbean	13 (0.1%)	1 (0.01%)	1 (0.03%
	Mixed: White and Black African	2 (0.01%)	6 (0.05%)	3 (0.08%)
	Mixed: White and Asian	14 (0.1%)	9 (0.07%)	17 (0.4%)
	Mixed: Other Mixed	16 (0.1%)	4 (0.03%)	4 (0.1%)
Asian or Asian British:	Asian or Asian British: Indian	2 (0.02%)	5 (0.04%)	4 (0.1%)
	Asian or Asian British: Pakistani	0	1 (0.01%)	0
	Asian or Asian British: Bangladeshi	0	3 (0.02%)	1 (0.1%)
	Asian or Asian British: Other Asian	4 (0.03%)	3 (0.02%)	19 (0.5%)
Black or Black British:	Black or Black British: Black Caribbean	3 (0.02%)	0	1 (0.1%)
	Black or Black British: Black African	3 (0.02%)	1 (0.01%)	1 (0.1%)
	Black or Black British: Other Black	1 (0.001%)	2 (0.02%)	4 (0.1%)
Chinese or other ethnic group:	Chinese or Other Ethnic Group: Chinese	13 (0.1%)	7 (0.06%)	16 (0.4%)
	Chinese or Other Ethnic Group: Other	15 (0.1%)	13 (0.1%)	5 (0.1%)
Not Known		2159 (16%)	1607 (12.7%)	93 (2.4%)
Cornish		688 (5.1%)	528 (4.2%)	149 (3.8%)

Access to urgent care thorough Accident & Emergency

Access to urgent care out of hours by attending Accident & Emergency at the Royal Cornwall Hospital (RCHT) may indicate poor health and a need for urgent care or reflect access to primary care. It may also reflect cultural beliefs of health care, i.e. a choice not to engage with the GP and Primary Care Services for a number of reasons.

Migrant workers, particularly in the agriculture and service industries work long and late hours, outside of the traditional GP surgery hours that are available. Many people who describe themselves belonging to a Black and Minority Ethnic Group work in the service industry and restaurant trade which incur long and less sociable hours, creating difficulties in getting time off to visit the GP.

Gypsy and Traveller research (O'Neill R & Dow M 2002) suggests that the preference for attending an A&E department over a GP surgery was in part attributed to difficulties with the concept of making an appointment and the perception that GP surgeries discriminate against Gypsies and Travellers.

The Accident and Emergency department has been recording ethnicity since 1st April 2009 which is entered directly to a satellite system of PAS. For a short while prior to this the department trialled the recording of ethnicity and felt that there were barriers to asking a patient to describe their ethnicity. The barriers were not just the urgency of treatment required but embarrassment and concern of offending patients. They have overcome this by

having a list of prescribed codes on the reception desk and ask the patient, during the process of obtaining other essential information, to indicate which of the categories they would chose to best describe themselves.

Contact with the department at RCHT identified that Gypsies and Travellers often turn up at A&E with minor illnesses such as a cold or temperature because no appointments are required. The department treats a number of BME people and migrant workers; an increasing number of Lithuanians have attended A&E recently. The triage staff determine the severity of the presenting illness or injury and if it is more appropriate for the patient to be seen in primary care then they are directed towards Kernow Urgent Care.

Further investigation is required to identify the severity of presenting illness and ethnicity which may indicate A&E use in preference for primary care.

COMMUNICATION AND INFORMATION

Interviews with Amber Initiative and the Community Development workers have identified a need for basic information to access interpreter services. Although the use of interpreters in health situations is identified in the Migrant Workers Pack, more information could be given on how to arrange this. For many Gypsies and Travellers, information is not available in forms they can access if they are struggling with the written word and many get their information from the television.

Each Migrant Worker community has its own communication links and means of transferring information. Members of the Pool group (LINC 2006) said that information from workers already in the UK was passed back to people in Poland; as a result new people moving were more aware of where to look for information.

The Migrant Worker Pack explains how to access health services and is written in 4 languages; English, Polish, Portuguese and Russian. Nationally acclaimed, it identifies how to register with a GP, access emergency treatment, dentists, drugs helpline, sexual health and helpful telephone numbers. The section on health in the 2006 pack identified free and accessible treatment at A&E and how to get an ambulance mentioning GP registration as an option rather than insisting that this is the gateway to health care. The new 2009 pack has a more comprehensive health section which now recommends:-

"When you arrive in a new area you should register with a local GP (doctor) as soon as you can. This is free. Your GP will be able to give you advice and prescribe medicine for you, as well as telling you about other free services you can get, eg……"

Continuity in the interpreters used, where possible, has been requested so that an element of trust can build up between the person using the interpreting service and the patient.

Of the GP practices contacted for this audit, a number of GP receptionists have not taken up opportunities for Equality and Diversity training which could enrich the experience of contact with the GP surgery for patients.

Cornwall and the Isles of Scilly Primary Care Trust has a long history of engagement, and has works with the recently established 'Local Involvement Network' (LINks). One example of consultation is the Equality Scheme Consultation and Involvement events which took place in April and May 2009 at venues across Cornwall and Isles of Scilly.

FUTURE DEVELOPMENTS

Cornwall and Isles of Scilly PCT is developing GP led services in the west of the county, which will have a focus on ease of access for medical care for the migrant workforce within the county. The PCT has made equality and diversity issues compulsory within the bidding and evaluating process for the 'Easy Access to Primary Care Initiative', forcing would-be providers to think innovatively about ways to provide services to groups of people for whom there may be access difficulties. The PCT is developing a leaflet promoting access to health care and creating a document on how to ask for ethnicity for registrants.

Amber initiatives are producing a leaflet in 12 different languages and an article on access to health care – what the services are and how to register

Engagement to positively include BME people and Migrant Workers is a high priority within the Trust.

CONCLUSION AND RECOMMENDATIONS

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.

Solutions are not about separate services for people from 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. The priority in ensuring equitable access to people from differing communities, with diverse beliefs about health, should be the ability to record ethnicity and therefore have an ability to demonstrate equality of access.

The aim of this health equity audit was to investigate inequities in access to primary care resulting from differences in ethnic origin. However, the quality of information needed to undertake such an assessment is at best poor and at its worst is not even collected. This conclusion has also been reached by others who have attempted similar audits, most notably the Association of Public Health Observatories.

There are good examples of working to both encourage access to Primary Care and demonstrate fair access for BME people. For example, Kernow Urgent Care Services, MIUs and A&E in the positive way they direct people to appropriate care and encourage GP registration. The development of a leaflet to encourage registration will help in signposting services. There is a fantastic resource in the form of the Migrant Worker pack which extends beyond migrant workers and the lessons learned from A&E about ethnicity recording could be shared.

Establishing the ethnicity profile of GP practice patient populations requires more than an opportunistic approach to data collection. Ethnicity profiling should be part of a wider information gathering exercise that should include information about religion and languages, both spoken and read.

22.1 There is inconsistent and insufficient evidence of recording of ethnicity in primary care when patients register with a GP. Although there is now a requirement for ethnicity and language spoken to be recorded for all patients under the new Directly Enhanced Services for General Medical Service contracts, not all Practices have taken up this initiative. Staff confidence in asking a patient for their ethnicity needs supporting so that this can be done in a sensitive manner.

Recommendation 1

- A person's ethnicity should part of all patient information that is routinely collected. Each patient contact with Primary Care Services should be an opportunity to ensure that this information is recorded where it is absent.
- Staff should be supported in approaches to asking people to describe their ethnicity.

Actions discussed and/or implemented through Equality & Human Rights Commissioning Sub-Committee

- Checking and recording of ethnicity against established records at each interface with Primary Care – Responsibility of GPs, Receptionists, Community Health care staff.
- Approaches to ethnicity recording to be included in Equality and Diversity training – Responsibility of Primary Care Services.
- Encourage compliance with Directly Enhanced Services guidance 2008/09 for recording of ethnicity and first language – Responsibility of Primary Care Services and General Practice.

22.2 The EXETER system and many other data systems do not possess fields for the recording of ethnicity. These systems need improving to enable the proficient, sensitive and acceptable recording of ethnicity for patients who use Primary Care Services. The current level of recording does not permit conclusions to be drawn regarding equity of access until the level knowledge around ethnicity improves.

Recommendation 2

- Patient data systems eg Exeter, PAS and MIU should have the capability to record ethnicity with an appropriate drop-down menu. Capability potential of current systems should be investigated and the readiness of future systems e.g. NPFIT
- Systems that are used to record ethnicity should not enable staff to skip data entry fields used to record a patient's ethnicity.
- Recording of ethnicity should be mandatory for newly registered patients and existing patients. Opportunity should be taken at every patient contact to ensure that current details are correct and up-to-date.
- The IT infrastructure should enable this possibility by investigation into the possibilities of the current system or investment into new systems and roll out of the national NHS IT infrastructure.

Action discussed and/or implemented through Equality & Human Rights Commissioning Sub-Committee

Mandatory fields for recording ethnicity and language support required on patient data systems in primary care – Responsibility of Cornwall IT.

22.3 There is a wealth of evidence from studies undertaken in other parts of the country suggesting problems and successes of access to primary care for people from Black and Minority Ethnic backgrounds, Migrant workers and Gypsy & Traveller communities.

The best evidence comes from the National Patient Survey 2007/2008 which incorporated information from 35,000 Cornish residents.

The survey results for 07/08 were available on-line by GP practice but results displayed identified ethnicity for one question only and the ethnicity codes were crudely categorised. This could be a valuable resource for measuring equitable access to Primary Care.

Recommendation 3

- On-line data by GP practice, from the annual National Patient Survey should be available for all audit areas and defined by the 16 standard ethnicity codes as well as the two broad categories currently used. This would improve local annual auditing of access to primary care.

Action discussed and/or implemented through Equality & Human Rights Commisioning Sub-Committee

- Primary Care to conduct audit using output from National GP survey to describe all criteria by ethnicity – Responsibility of Primary Care Services and General Practices.

22.4 Receptionists at GP surgeries are often the first face-to-face encounter at health services and can present the welcoming face of the NHS. A few reception staff that were contacted had not experienced equality and diversity training; it is unclear what the picture is across the Cornwall and Isles of Scilly.

Recommendation 4

A patient's experience with Primary Care could be enriched by staff who regularly access equality and diversity training.

- Wide participation could be encouraged by the use of on-line resources and implemented as part of induction and annual reviews.

Action discussed and/or implemented through Equality & Human Rights Commissioning Sub-Committee

- Equality and diversity training programme for GP Receptionists. Responsibility of Primary Care Services and General Practices.

22.5 The use of interpretation services is not consistent across Cornwall and Isles of Scilly and concern has been expressed about staff knowledge of the service and use of family members for interpreting.

Recommendation 5

- Improve staff knowledge of the interpreter services and how to access them
- Improve patient information about access to interpreter services

- Translation cards should be developed and used.
- GP systems should identify patients who require language support in compliance with the Clinical Directed Enhanced Services guidance 2008/09

Actions discussed and/or implemented through Equality & Human Rights Commissioning Sub-Committee

- Increased staff knowledge of interpreter services. Responsibility of Primary Care Services and General Practices.
- Advertising of interpreter services in each GP surgery. Responsibility of Primary Care Services and General Practices.

Translation cards already in GP surgeries. (See Appendix B - Cornwall and Isles of Scilly Health Promotion service recommendations on communication with BME groups in the GP surgery and the wider community)

22.6 People from Black and Minority Ethnic Communities have not submitted formal complaints to the Trust in the last 12 months (April 2009).

Recommendation 6

- Increase communication and feedback from Minority Ethnic Communities.

Actions discussed and/or implemented through Equality & Human Rights Commissioning Sub-Committee

- Development of a form of newsletter accessible by BME people. Responsibility of Primary Care Services and General Practice. Already completed - articles relevant to BME will be put into Your Health Voice newsletter.
- Wide distribution of 2009 Migrant Workers Pack. Responsibility of MigWAG, Primary Care Services, GP Practices.

22.7 The practice of scanning passport photos for selective individuals in GP practices is not acceptable and is not endorsed by current PCT policies. Action has been taken to address this issue. GP practices have produced leaflets for new registrants requesting the production of a passport or European Health Insurance card to show entitlement to register.

Recommendation 7

- Ensure the scanning of passports is ceased.
- Culturally sensitive information should be visible in practices in an appropriate range of languages.

Action discussed and/or implemented through Equality & Human Rights Commissioning Sub-Committee

Cessation of scanning passports. Responsibility of Primary Care Services and General Practices.

APPENDIX A
Case studies submitted by the Community Development Workers (CDW)

1 A Polish woman was accompanied by a Community Development Worker to a GP appointment to help with communication as she was refused an interpreter at her appointment. She was suffering from extreme back pain after an accident at work. She also said that she takes medicine by injection when she is in pain. She stopped taking medicines prescribed by her doctor because she didn't feel well after them, she felt very nauseous. The doctor said that there was no way that she could feel sick after drugs he previously gave her and asked her to continue taking them. Also he advised her to stop injecting herself and asked if she had problems sleeping. She said that she has trouble a couple of times a week falling asleep.

Then he gave her a prescription and said to make another appointment to see him, however he didn't explain what he prescribed and how the medicine should be taken or if there were any side effects. She asked CDW to explain what the medicines were and the dosage. Two of the drugs were pain killers and they were equivalent to medicine that she was injecting to herself but in a lower dose. Two other drugs were antidepressants: Amitriptyline (two tablets at night) and Citalopram (one each day). There was no conversation about the drugs, alternative solutions, dosage, side effects etc.

- interpreters were refused on numerous occasions (CDW survey, informal interview)
- Secret shopper exercise; two phone calls were made in broken English/Polish. The purpose of the phone call was stated in English (registration). The receptionist on those two occasions hanged up.
- Appointments were refused on the day of a phone call, people were told they need to wait a few days for the appointment (CDW survey, informal interview)
- People had problems with registration (receptionist didn't explain registration procedure, informal interviews and survey)
- No information in other languages on display
- Poor ethnicity monitoring, no explanation why etc..

2 Surgery X

- One Polish woman who is a patient at Surgery X and speaks very good English was approached on a number of occasions by the receptionist to interpret for patients' appointments, although she is not a professional interpreter. She was phoned a few times and asked to do it over the phone, for free 'to help the practice' (evidence by interview).
- 7 Polish women were refused an interpreter for their appointments with midwives, although they indicated the need and wanted to know more about the pregnancy and birth procedures. Others were refused an interpreter for appointments with Health Visitors (evidence by interviews). Both incidents were flagged up with PALS but no further action was taken. CDW sent an email to meet up with the practice manager at Surgery X and help them with the above issues but no response had been received.
- A few Polish people were told if their English is not good enough they should change the practice or come with a friend or family member.
- Interviews with Polish and Portuguese people: one person was coming to the practice on a regular basis with bad chest pains, she was explaining the pain is sometimes unbearable and asked if she can see the specialist. The Doctor told her that everything is OK and she doesn't have to worry and he doesn't see the need for a cardiologist. After a few weeks she fainted at work and lost her breath. She was transferred to Treliske Hospital and diagnosed with a serious heart condition and had two heart operations since.

- one person came for the appointment with possible broken bones in the hand/fingers due to an accident at work, the Doctor looked at the hand and advised the patient to take a few paracetamols as everything looked 'normal'. A few days later the same person tried to make an appointment as his hand felt worse. He was informed that the Doctor was unable to see him on that day or the day after. He drove to the hospital and was diagnosed with a broken hand and two broken fingers.

Secret shopper exercise (same procedure and outcome as above)

- The general feeling is that people aren't listened to and taken seriously, interpreters are provided on rare occasions, people are treated in a patronising way and as if they 'aren't intelligent enough'.
- No information in other languages on display
- Poor ethnicity monitoring, no explanation why etc..

3. Surgeries Y & Z

- interpreters are offered on rare occasions
- secret shopper exercise (same procedure and outcome as above)
- poor ethnicity monitoring, no explanation why
- no information in different languages apart from one poster and back of a leaflet
- most people do not like the system of ringing a receptionist, explaining the reason for the appointment request and then be ringed back by the doctor.
- the surgery translated a leaflet into Polish, however it is on the back of a leaflet
- On a few occasions people were told that they can't see the doctor the same day they rang for an appointment
- People do not understand how the appointment system works when they come to the surgery. They have to tell the receptionist that they arrived or sign in electronically, which is not explained.
- A woman with a long term condition was refused to be given another sick note. She had a car accident and attended physiotherapy. Her therapist said that she was not ready for work but her GP said that it is enough for her to be on benefits, although she works as a cleaner in a very busy hotel and restaurant.

Appendix B

Cornwall and Isles of Scilly Health Promotion service recommendations on communication with BME groups in the GP surgery and the wider community.

In the Surgery Setting

To assist with the initial consultation process there are tools available which use simple diagrammatic representation to obtain key information. An example of the universal language tool is the PocketComms. This resource has been put to use in situations where language might present a barrier by the military and security operations and by the police. It has also been used with Stroke victims as well as with people with hearing difficulties and people with other disabilities. It is currently being used in the UK by more than 30 police forces.

The Standard PocketComms is designed to be useful in GPs surgeries, hospitals and other health service providers. There is also a School Nursing PocketComms which covers a wide range of health and health promotion topics.

The Stop Smoking Service is looking to design a similar resource specific to smoking cessation.

The benefit of this method is that only one resource is required to start a communication instantly.

To access more complex information translation and interpretation services may be required. These are already available within the County.

In addition to the above it may be possible to provide further or additional; information within the surgery environment. The Migrant Workers Welcome Pack is currently available within surgeries across the county. The pack contains information about the health service with some useful contact numbers in Cornwall and general health information. It mainly targets Polish, Portuguese and Russian speaking people and communities. This pack has been available for some years and continues to be used.

It may be possible to adapt this pack and by making it available in a wider range of languages enable it to be used more broadly. The choice of languages would be indicated through the Translation and Interpretation Service annual monitoring which would identify current requirements.

The Health Promotion Services holds a small stock of leaflets in a range of languages as they become available from other sources. It is also able to signpost to websites where professionals can access a broader range of information.

Although this service can be made available on request it would not be recommended as the best way forward. The supply is not secure and to produce our own in house leaflets is probably not sustainable. The Cornwall Migrant Workers Group have looked at this issue and have found that although there would be no difficulty knowing what information was needed the numbers for each publication would be small with specific needs so the cost could be very high.

The PCT has employed a number of people who have a learning disability (the CHAMPS) the aim of their work is to improve health services for people with learning disabilities. Part of their work has been to look at communication and they have produced a number of easy read leaflets and DVDs to facilitate understanding relating to NHS services and healthy lifestyle.
To date the following have been produced:

Your way to Health
Your guide to health services in C&IoS (leaflet and DVD)

Your Way to A healthy Mouth
Guide to dental services in C&IoS (leaflet)

Planning for a good discharge (DVD)
Key recommendations for planning the safe discharge of people with LD from Hospital

Your way to being active. (DVD)

The main method of communication employed in the above resources is visual with any written content being reduced to the absolute minimum. This again might be a useful tool to adapt and put to wider use. This type of communication also has support from community development workers with a suggestion that subtitles in different languages are added. This would target communities with low levels of literacy or ones that use the spoken word only.

Communicating within the community

Creating routes for communication

The idea of a newsletter would be supported by some community workers who have a specific brief for BME work. Although it is acknowledged that this communication method might prove to be problematic / costly in the same way that producing other materials such as leaflets using translation services would. A distribution system would also need to be put in place in partnership with community development services.

The alternatives to producing a newsletter may be identified by looking at some of our existing models of working.

The Health Trainer Model is working well because members of the community recognise them as belonging to their own community and can develop a trusting relationship with them. If information comes from them and not from a statutory and remote body the method of delivery and the information itself can be none threatening and trusted. This might be achieved by using a similar community model to Health Trainers but using BME champions or community activists. This would also be supported by Community Workers.
The Health Promotion Services has in the past used opportunities to provide health information by attending events such as the Pride and Respect festivals and wherever possible having leaflets in a variety of languages to support the health

messages. Where leaflets were not available signposting to appropriate website sources of information were provided. To have champions / activists attending these events to help with delivering the messages would be helpful.

It may also be possible with the help of BME champions to arrange local events or to attend existing local events to provide information that would be useful were there is a recognised BME presence. This would again be supported by Community Workers.

HPS has also supported BME groups such as Unity Cornwall by providing small grants to support health promoting activities.

Making best use of community workers across all agencies to champion the needs of BME people within the community and staff training for the NHS and other statutory bodies might make it easier for BME groups to access the services and information that they need.

What information should we communicate?

Basic communication during consultation to respond to immediate patient need
Information about NHS services and access to the same – contact numbers
Appropriate campaign information
Health Promotion information
Community activity information

APPENDIX C

Extract from Gypsy and Traveller survey – June 2010.

Full report available from Neal.Chambers@CIOSPCT.cornwall.nhs.uk

Author: Neal Chambers

Introduction

Gypsies and Travellers have a long and rich history, yet it is one that is also marked by persecution and discrimination. In Britain today, Gypsies and Travellers have the lowest life expectancy and lowest educational achievement of any ethnic group in the country. The average life expectancy of a Gypsy or Traveller woman is 12 years less than for a member of the settled community, and 13 years less for men. 18% of Gypsy and Traveller mothers will experience the death of a child, compared to 1% of the settled population. Only people who are homeless to the point of living on the streets and sleeping rough have a lower life expectancy. These are unacceptable health inequalities, and they act a powerful driver to establish genuine and ongoing engagement to help reduce the health gap for this community.

The PCTs own Joint Strategic Needs Assessment states:

Gypsies and travellers experience health inequality that is even more pronounced than that experienced by other socially deprived or excluded groups or ethnic minorities. Gypsies and Travellers who took part in Department of Health research reported poorer health over the past year than those in the housed population; and in terms of their health on the day of questioning, they had more problems with mobility, self care, undertaking usual activities, pain or discomfort and anxiety or depression. Regionally and nationally the number of Gypsies and Travellers has been growing. In Cornwall and Isles of Scilly there has been an increase of 13% in caravan numbers between 2003 and 2005, largely on unauthorised sites. Cornwall and Isles of Scilly has a lower proportion of private sites than elsewhere in the South West and the rest of England, and a higher proportion of unauthorised encampments.

For these reasons the PCT was keen to engage with Gypsies and Travellers, to learn from them about their access to and experiences of healthcare, and to use that information to help improve health services for them.

Background to the engagement

NHS Cornwall and Isles of Scilly have an ambitious programme of patient and public involvement (PPI) as part of its Corporate Communications and Engagement Strategy. This includes a commitment to reach all sectors of the community, and requires extra effort to be mad to ensure that people who might not otherwise have their voice heard or engage with the NHS are encouraged and enabled to do so.

The stated aims of the engagement were:

- to increase awareness of the Redruth walk-in health centre among the Gypsy Traveller population and improve their access to primary care services so as to reduce the chance of minor injury or illness going untreated
- to communicate stop smoking messages to the Gypsy and Traveller population to encourage a reduction of smoking among this group.
- to better understand the needs of the Gypsy and Traveller population so that we can include them in our commissioning strategies
- to better understand the barriers that can prevent Gypsies and Travellers from accessing health care

Methodology

Relationships between Gypsies and Travellers and statutory organisations nationally have a chequered past. This can make some members of these communities cautious about engaging with an organisation like the NHS. For this reason it was decided to commission TravellerSpace, an independent voluntary organisation that supports Gypsies, Irish Travellers and New Travellers across the southwest, to undertake the actual engagement. TravellerSpace have the trust and confidence of a great many Gypsies and Travellers on official sites in the county, and also have the ability to engage with people on unofficial sites and on the roadside which would have been difficult, if not impossible for the local NHS to achieve.

Neal Chambers, PPI Manager for NHS Cornwall and Isles of Scilly met with Caroline Dann (TravellerSpace) and Tamsin Dearing (Community Development Worker, Pentreath Industries) to discuss how the engagement would be designed to meet the four stated aims.

The final choice was to use a questionnaire based survey to measure people's access to healthcare, the barriers to healthcare that they face, and their experience of using healthcare. It would also provide a means to measure awareness of the walk-in centre in Redruth, and distribute health promotion information to anyone willing to receive it.

TravellerSpace undertook to work with a small number of people from within the Gypsy and Traveller community who would act as champions for the engagement, and who would encourage people within their communities to participate in the survey and be able to help complete the questionnaire (if someone had problems with literacy or poor vision), and distribute health promotion material. With the help of the Health Promotion Department a range of material was collated and shared with TravellerSpace for distribution.

Conclusions:

This is a small survey that provides a snapshot of access to health care for Gypsies and Travellers in the east and west of the county living on official and unofficial sites, plus the views and experiences of some people living on the road. The survey response rate was not helped by the particularly difficult weather during the period of the survey.

However, it does provide a benchmark specific to Cornwall for a set of measures about access to healthcare, and the questions are designed so that the survey can be repeated to provide cumulative, comparable data. The survey also captures patient experience information.

Positive finding are:

- levels of GP registration among Gypsies and Travellers excluding those with no fixed abode are on a par with the rest of the population
- many respondents report positive encounters when using the NHS
- levels of access to NHS dental care is similar to that of much of the settled population
- there is good awareness of the facilities at Cardrew Way in Redruth
- take up of health promotion material was good

Negative findings are:

- levels of GP registration among people with no fixed abode are very low
- negative attitudes by some staff towards Gypsies and Travellers still exist in some areas
- getting to appointments can be a challenge

Issues for consideration are:

- how to provide the means for Gypsies and Travellers who so wish to become involved in influencing health service decisions
- maintaining awareness among Gypsies and Travellers of the facilities at Cardrew Way, Redruth

APPENDIX D

CARDREW HEALTH CENTRE

Report by Lucy Hunt, Compliance and Performance Manager

Background

Cardrew Health Centre opened in August 2009 and provides all of the usual General Practice facilities for registered patients.

The centre also offers a walk in service which operates from 8am to 8pm 7 days a week.

Patients and the public are able to access Health Care via the walk in service without being a registered patient of the centre.

The centre has a comprehensive website and in addition, the details of the Health Centre are included on the message patients receive when they contact the Out of Hours service and several Pharmacies in the county advertise the centre.

The centre is designed to provide significantly improved access to General Practice services for the county. This has been very successful and the centre has already surpassed the targets set by the PCT for both registered and walk in patients.

Clinical Services

Cardrew offers all of the usual General practice facilities for registered patients, including Chronic disease management, via the Quality and Outcomes Framework and a full range of Enhanced Services, which will shortly include the Drugs Misuse Enhanced Service.

This full range of services is also available to walk in patients, with the exception of Chronic disease management, which would not be appropriate on a walk in basis.

Patient Numbers

Since the centre opened in August 2009, to the end of February 2010, 324 patients have registered with the health centre.

The target for registration for the August to February time frame was, 262.

For walk in patients, data is available for the slightly extended time frame August to end of March.

During this time 6086 appointments were accessed by walk in patients.

For reference, up to the end of February the total figure for appointments accessed by walk in patients since opening in August was 4561 walk in patients.

Gypsy and Traveller communities

The centre is doing a significant amount of work with the Gypsy and Traveller communities who have historically been difficult to reach and often have complex health problems.

The centre has seen an increase in numbers attending from these groups who often turn up in large numbers at the practice towards the end of the day. In most cases the centre is providing the only regular access to healthcare these communities have received.

An example of the work the staff at Cardrew are doing with the Gypsy and Traveller communities, is encouraging the uptake of childhood immunisations and contraceptive services, particularly amongst the young women and girls.

This has proved surprisingly effective in a community that does not usually take advantage of these services, with several of the young women and teenage girls having contraceptive implants and families bringing in their children to be immunised.

This success is largely due to the work the Practice manager and the other clinical and non clinical staff have done to create a raport and a level of trust with the community.

Outreach / Polish and Eastern European communities / Chlamydia screening

The clinical and non clinical staff are also conducting outreach work to local farms to directly provide healthcare and also raise awareness of the centre, to migrant workers from Poland and several of the former Soviet States.

As part of this outreach staff have conducted mass Chlamydia screening, on behalf of the PCT.

Also Health Packs containing health, housing and benefits information, are distributed to the migrant workers.

The outreach work has proved successful and the workers are now regularly accessing the centre.

The centre employ a Polish receptionist and practice information available in Polish and several other Eastern European languages.

Ethnicity / Disability monitoring

The practice records 100% of patients Ethnic origin, First Language, Disability status and whether they are a Carer.

LGBT

The centre is being regularly accessed by members of the LGBT community and staff from the centre, will be attending Cornwall Pride.

Patient Satisfaction

The centre has achieved 100% patient satisfaction.

General Engagement

The Health centre is preparing an engagement strategy for the forthcoming year.

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