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Are they slipping through the net? Improving the engagement of the National Health Service with minority communities

Sikhs – a community particularly vulnerable to diabetes

Key messages

- **Not all communities understanding how to engage with the NHS**
- **In some communities attitudes are affected by how health services were delivered in their countries they or their parents came from**
- **In some communities other people's awareness of your condition can result in very negative social attitudes**

Context

The health service benefits from an excellent range of research studies which have shown differences in the degree to which members of different communities are susceptible to different conditions. Everyone involved in the health service knows that children of West Indian descent are especially vulnerable to sickle cell anaemia, that diabetes is a particularly common condition in Britain's South Asian communities.

What are much less commonly understood are the differences in the way in which members of Britain's minority communities engage, or fail to engage, with the National Health Service. At Webber Phillips we specialise in using evidence to show differences in the behaviours of members of Britain's different minorities. Differences in engagement with health are at least as great as differences in any other domain. Whenever we examine information on engagement with the NHS we find great differences in their willingness to use different services and their response to different communications strategies.

These differences are largely the result of difference in cultural inheritance – not genetic inheritance – although often the two do interact. These differences often render the attempts of the health service to target vulnerable group less effective than they could be.

Evidence

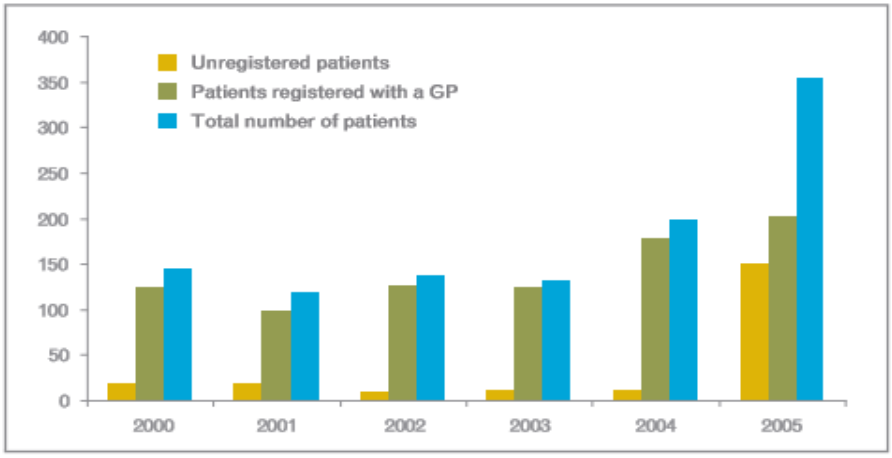
Poles in Telford

The Princess Royal Hospital, Telford

One of the earliest uses of Origins in the health service was by Dr Andrew Leaman, a consultant at the Princess Royal Hospital, Telford. In 2010, sensing that there had been a very marked increase in the number of Poles attending the hospital's A & E department, Dr Leaman analysed the names of all patients treated in the department in the previous five years. Using Origins technology he was able to demonstrate that his suspicion was correct. The proportion of patients with Polish names had doubled in a single year between 2004 and 2005.

What Dr Leaman had not expected to find from this analysis was that the entire growth in the number of Poles attending Accident and Emergency was accounted for by patients who were not registered with a general practitioner. On the other hand it did make intuitive sense.

One implication of the research finding was that the health and safety inspectorate might usefully encourage building contractors to instil greater awareness of safety procedures among their increasingly Eastern European workforce. More relevant to the NHS was that the local Polish media should be contacted in a campaign to alert recently arrived Poles of the need to register with a GP and, other than in an emergency, to visit their doctor rather than the Princess Royal hospital.



Annual visits to A & E by people with Polish names

Sikhs in Slough

Medical research consistently shows that members of Britain's Sikh community are among the most likely to suffer from diabetes. Finding more effective methods of alerting the Sikh population to the importance of diabetes screening was the object of a project the undertaken in Slough with our assistance. Although at that time we were not in a position to produce maps showing the location of the Sikh population down to postcode level and for the current year we were able to show them the precise areas of Slough to which a communications programme should be targeted and which GP surgeries were situated within predominantly Sikh neighbourhoods.

The case book published for Slough PCT at the conclusion of their project reported how members of the Sikh community were particularly reluctant to make use of screening services on account of the "shame" that would accrue to them and their families if it were to be discovered that they suffered from this condition. Indeed it was discovered that a number of Sikhs were deterred from attending the screening centre lest a positive diagnosis compromise their marriage prospects. Such a fear, it was argued, could best be overcome with the support of the local Sikh elders who proved to be delighted to add their influence to a campaign with a particular focus on their community.

Black Africans in London

A campaign where maps of up-to-date statistics of specific ethnic groups did prove useful was one conducted by Prostate Cancer UK. The target for this campaign was persons of Black West Indian and Black African descent. The definition of this group included those with Somali, Eritrean and Ethiopian names as well as those from sub-Saharan Africa. The use of a names database at postcode sector level made it possible to define this group much more accurately than would have been

possible using 2011 statistics, at a much finer geographical level and using information at the time only five months old, unlike the census which by then was five years out of date.

Bangladeshis in Camden

In another study of people attending a London hospital, we were given access to a list of names of people failing to turn up at a consultant's appointment. It became evident that the community whose members were most at risk from non-attendance was Muslim Bangladeshis.

Royal Free Hospital, Camden

These findings led to a concerted effort to communicate with people with Muslim Bangladeshi names shortly before the date of their referral to check that they would be attending. In many instances it was evident that non-attendance was the result of not having a companion to travel with them, a cultural requirements which, so it appeared, was a particular issue among Bangladeshis. This information enabled the hospital to assist with arrangements for the visit and to rebook appointments where appropriate.

Bangladeshis in Tower Hamlets

Dr Foster was also involved in a project in Tower Hamlets which investigated the excessive use of A&E facilities by those who ought to have referred themselves to their local GP. Their project report explains how from analysis of names they became aware that people of Bangladeshi origin were particularly likely to use accident and emergency departments for conditions which they should have referred to a local GP. Qualitative analysis revealed that a major reason for this was that people of Bangladeshi origin expected professional doctors to wear white coats, to carry stethoscopes and not to address their patients by their first name. Not experiencing such behaviours when they visited local surgeries, where doctors were attempting to act in a less formal way towards their clients, many Bangladeshis concluded that in Britain, if one was to secure the services of a professionally competent medic, it was necessary to visit an Accident & Emergency department where everyone wore a white coat. This is what they were used to in Bangladesh.

Muslims in Birmingham

Having established that women with Muslim names had a much higher than average risk of giving birth to babies with very low birth weights, a Birmingham health authority was able to justify targeting specific support services at these expectant mothers and, equally important, to track the impact on infant mortality among this population group due to their intervention strategy.

Likewise through a study of the structure of different strains of tuberculosis the Heart of England NHS Trust in Birmingham has been able to associate many tuberculosis strains with specific epicentres within the Indian sub-continent. By linking this information with the names associated with these regions the Trust believes it can identify individuals with the highest risk of carrying and transmitting particular strains.

Insight

It is our feeling that the cultural awareness training that is provided to staff in the NHS tends to focus on how to avoid giving offence to members of particular minority groups, which is not a bad thing in itself, rather than understanding the cultural presumptions with which members of difference communities approach their engagement with the NHS.

In the case of the Muslim mothers in Birmingham, the potential prostate suffers among London's Black African and Caribbean communities and the potential diabetics among Slough's Sikh population we can see considerable advantages in targeting communications with greater precision to high risk groups.

Both with the Bangladeshis in East London and the Poles in Telford analysis of the health service provide than people actually use can demonstrate the need for more targeted information on how best to engage with the NHS and in particular avoid the overloading of A & E services.

In both cases and in the case of the Sikhs in Slough it became evident that communicating these messages to very discrete groups did require an understanding of the channels which local communities relied on for information. An English language stand outside a supermarket might be an effective channel elsewhere but in Slough it proved an abject failure for reading the local Sikh population who were much more influenced by leaders of the local religious community.

Both in reaching Sikhs in Slough and Black Africans in London, maps of local concentrations proved useful for identifying local GP practices (Slough) and poster sites on suburban railway stations (London) which maximised the efficiency with which the target group could be reached.

Both among the Bangladeshi Muslims in Camden and sub-Saharan African in London, names demonstrated their ability to identify more discrete target groups than using just a single dimension such as country of origin or religion.

A final source of insight, when the profile of service users is compared with staff, as it was in Camden, is the extent to which users of the health service can recognise members of their own community when they visit a hospital and what roles members of that community play. Though this

requires more study we do believe it is an important issue when considering the confidence with which different communities feel they can engage with the NHS.

Implications

At Webber Phillips we believe these are a number of implications that can be drawn from these examples of the use of names in the health service:

- These particular case studies illustrate just a small number of the differences that exist between Britain's minority communities in how they tend to engage with the NHS.
- It would be helpful if those responsible for "equalities" could interpret their role more widely than compliance by understanding and addressing the cultural expectations that are quite deep-rooted in many minority communities.
- Although many health providers would benefit from better analysis of channels and outcomes using name profiling, analytic capacity is limited and there is scope for cross-communication of findings between different health providers.
- Differences in genetic make up are likely to result in there being a need to target communications strategies at particular groups. So it is important to understand which communications strategies and channels work best for each major group.
- Very considerable improvements in efficiency can be achieved by targeting relevant groups with appropriate messages using effective communication channels. This should also lead to greater satisfaction with the NHS, less anxiety and a more sympathetic response on the part of other community members to particular diagnoses.

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