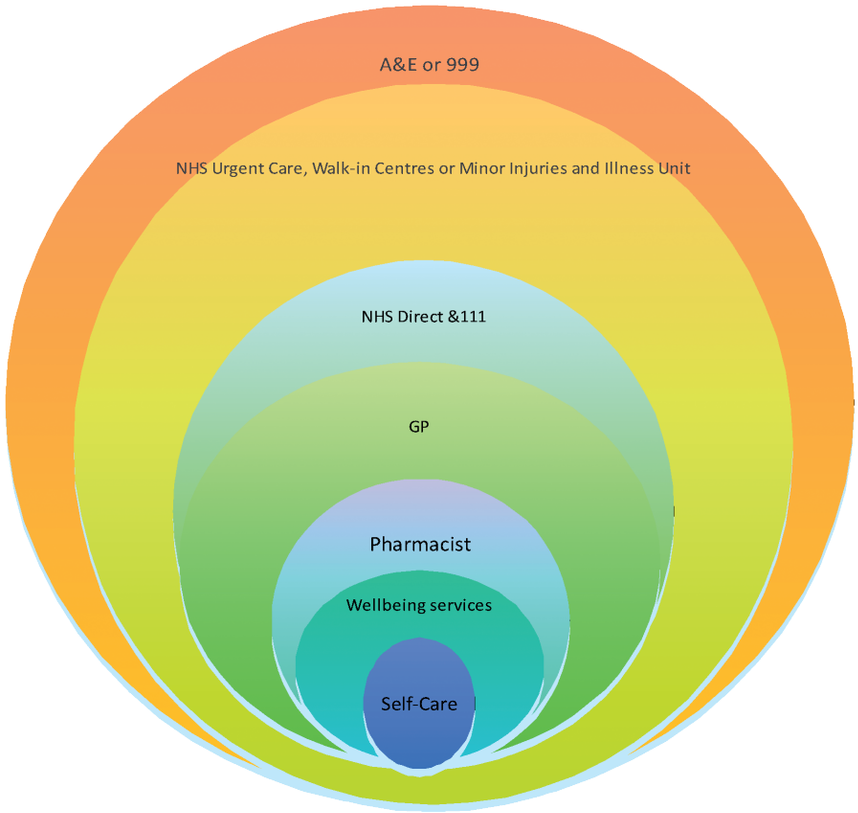
Emergency or Not?



UNSCHEDULED CARE INSIGHT PROJECT

A Report by the

BME healthforum

April 2014

Commissioned by the NHS Central London CCG

'You go to the A&E if you need something urgent. You go to the doctor for normal things. Different services.' Patient quote

Acknowledgements

There are many people who made the Unscheduled Care Insight Project possible. Some of the people who were integral to its inception, progress and culmination are mentioned below.

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Staff and volunteers worked hard within time constraints and other work commitments to co-produce this project from the very beginning when we were putting together the questionnaire to actually carrying out the interviews with the participants and the report writing stage.

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Contents

1. Executive Summary

1.1. Introduction

The Unscheduled Care Insight project was funded by the NHS Central London Clinical Commissioning Group (CLCCG). The project's primary aim was to gather insight into the patterns of unscheduled care utilisation in deprived communities. The project was co-produced with five organisations; Midaye, Healthier life 4 You, Abbey Community Centre, Marylebone Bangladesh Society and Westminster Mind.

1.2. Methodology

The BME Health Forum recruited, via an open recruitment process, 5 community organisations that work with clients from deprived communities in the area covered by NHS Central London CCG to deliver the project.

A questionnaire was produced by the BME Health Forum, the 5 community organisations (staff and volunteers) and the commissioners. Volunteers nominated by the community organisations were trained to interview participants. In total 131 interviews (of 76 questions) were conducted.

The following selection criteria was used to recruit participants to take part in the research:

- All the participants had to be registered with a GP within the NHS Central London CCG (see Appendix 1 for details) OR
- Live within the NHS Central London CCG catchment area and not registered with a GP at all

Additionally, the participants had to meet at least one of the following criteria:

- Patients with long term conditions (LTC) such as diabetes, heart disease etc
- Parents of children with LTC (e.g. asthma etc)
- Adults without long term conditions who are frequent users of A&E (e.g. 3 times in the last 2 years)
- Parents of children without long term conditions who are frequent users of A&E (e.g. 3 times in the last 2 years)

1.3. Demography

Of the 131 participants, 90 (68%) people were fluent in English and 41(32%) were not fluent in English. 67 people responded to the question about using an interpreter with 30% having used an interpreter and 70% had not used an interpreter.

Most of the participants (81%) were female and 73% had LTCs. Half the participants had children under 18, while 19% had children under 18 years old with LTCs. Most

of the participants (83%) were unemployed and of those who were employed, half were in part-time work. Of the unemployed women, 20% had children with LTCs.

The largest age group who took part in the survey were people in their forties (29%) with 25% in their thirties and 17% in their fifties. Twelve percent were in their twenties, 11% in their sixties with 5% in their seventies and just 1% in their eighties.

Participants were asked to describe their ethnicity and there were a lot of different characterisations of how people saw their ethnicity. In total 87% of the participants were from the BME communities.

1.4. Summary of Findings

1.4.1 The majority of respondents valued their relationship with their GP practice and particularly their regular GP (when they had one). For example, 63% of respondents felt their healthcare at their GP practice was 'good' or 'excellent' (See section 5.11 Q: Do you feel you receive good healthcare when you go to your GP surgery?), while 82% said they were 'happy' or 'very happy' with their regular GP (see section 5.16 Q: How happy are you with your regular GP at your practice?). Additionally, 75% thought their regular GP was a 'good' or 'very good' listener (See section 5.17 'Do you think your regular GP in your practice is a good listener?') and 64% felt able to discuss their emotional wellbeing with their GP (See section 5.18 Q: Do you feel you can discuss issues relating to emotional wellbeing with your GP?).

1.4.2 The majority of participants (57%) felt that A&E offers a better service than their GP practice. Only 28% thought that GPs offered a better service than A&E (See section 5.8, Question: Which service do you feel provides a better service? Your GP or A&E?). Also 74% felt their healthcare was good or excellent at A&E while 63% felt their care was good or excellent at a GP practice (See sections 5.11 and 5.12. Qs: Do you feel you receive good healthcare when you go to your GP surgery?; Do you feel you receive good healthcare at A&E?). Finally 46% felt fully involved or involved a lot in their healthcare at A&E compared to 34% in GP practices (See Sections 5.9 and 5.10 Qs: How involved do you feel you are in your healthcare when you go to your GP surgery?; How involved in your healthcare are you when you go to A&E?).

1.4.3 While the majority of respondents were satisfied with their care at their GP practice, a considerable minority were not. For example, 11% felt that their care at their GP was 'poor' or 'very poor' (See section 5.11 Q: Do you feel you receive good healthcare when you go to your GP surgery?). Similarly, 13% were 'unhappy' or 'very unhappy' with their regular GP at their practice (See section 5.16 Q: How happy are you with your regular GP at your practice?) while 12% thought their GP was a 'bad' or 'very bad' listener (See section

5.17 ‘Do you think your regular GP in your practice is a good listener?’) and 36% would not discuss emotional wellbeing with their GP (See section 5.18 Q: Do you feel you can discuss issues relating to emotional wellbeing with your GP?). Also, 26% were ‘unsatisfied’ or ‘very unsatisfied’ with the process of booking appointments at their practice (See section 5.21, Q: How satisfied are you with the process of booking appointments at your practice?) and 21% were ‘unhappy’ or ‘very unhappy’ with their GP’s opening hours (See section 5.15 Q: How happy are you with your GP practice’s opening hours?). Finally, 21% were ‘unsatisfied or ‘very unsatisfied’ by the way they were treated by reception staff at their GP surgery, (See section 5.22 Q: How satisfied are you with how reception staff treat you at the GP surgery) while 45% felt a little or not at all involved in their healthcare at the GP surgery (See Sections 5.9 Q: How involved do you feel you are in your healthcare when you go to your GP surgery?)

1.4.4 Overwhelmingly, patients who perceive themselves as needing care urgently want to be seen quickly. When asked about their visits to A&E within the last two years and were asked how quickly they felt they needed to be seen, 88% responded that they needed to be seen within 4 hours while no respondents felt they could have waited longer than 12 hours (See section 5.2). However when asked ‘Within the last two years when you have needed to see a GP urgently, how quickly were you able to see a doctor at your practice’ only 50% of patients reported being seen within 12 hours (See section 5.3). When people were asked why they went to A&E without trying to go to the GP first, 67% replied because they would not be seen quickly enough, rather than because the issue could not be dealt with at a GP practice or because they were not registered with a GP (See section 5.4). Finally, when respondents were asked what changes would make them go to a GP rather than A&E, 59% selected same day appointments. (See section 5.31 Q: What changes would make it more likely for you to go to your GP rather than A&E?) This suggests that changes in how quickly people could be seen in primary care would have the biggest impact in terms of reducing A&E attendances.

1.4.5 Most respondents said that they would be willing to go to their GP instead of A&E on certain occasions if changes were made (See section 5.31 Q: What changes would make it more likely for you to go to your GP rather than A&E?) The most popular change was same day appointments (59%), better facilities, equipment and tests (41%), more faith in the GP’s expertise (17%) and a better relationship with the GP (16%). The qualitative responses (See sections 5.6 ‘What would make you do something different next time? (that is go to your GP rather than A&E) and 5.31 Q: What changes would make it more likely for you to go to your GP rather than A&E?;) showed that patients had no awareness of how to seek medical help besides A&E when GP surgeries were shut. Respondents suggested GP surgeries opened in the

evenings and on weekends, and that they had better systems for booking urgent appointments that did not rely on a brief time slot to call and had greater capacity. Furthermore, nearly a third of the participants had been in a situation where after visiting the GP they still had to go to A&E. (See section 5.6 Q: If you saw the GP, why did you feel you still had to go to A&E?) In half of these cases, they said they were advised to go by their GP. The rest were either dissatisfied with their treatment or unable to book a second appointment with the GP when symptoms worsened.

1.5. Recommendations

1.5.1. Recommendations for changes in Primary Care

Most patients report having positive relationships with their regular GPs (See Findings 1.4.1). Most patients felt their regular GPs were good listeners and provided a good service. This is the foundation for the other recommendations.

1. Findings have shown that those who feel that they need urgent care want to be seen quickly and that they have little awareness of other options besides A&E when their practice is closed. Overwhelmingly, the most significant reason for attending A&E rather than a GP practice was the speed with which people could be seen. (See Findings 1.4.4 &1.4.5). To rectify this we make the following recommendations based on the respondents' suggestions (See sections 5.6 and 5.31):

    a. A guarantee to patients that when they have an urgent need they can be seen by a GP in a GP surgery, Urgent Care Centre, Walk-in Centre or Out Of Hours service within 4 hours.
    b. Pilot drop in clinics that are open late in the evening (e.g. until midnight)
    c. Raise awareness on the availability of Out Of Hours services through direct conversations with patients as this group of patients do not access information though mainstream publicity such as GP practice websites.
    d. Ensure every GP practice has an effective and consistent appointments system for seeing urgent cases, particularly children and older people within 4 hours during their opening hours.

2. Work with health professionals about when it is suitable to advise patients to go to A&E. Many patients reported that they were advised to go to A&E by GPs but also by other staff such as pharmacists or receptionists. (See Findings 1.4.5 and Sections 5.6, 5.7, 5.32). While this may often be the correct advice, there may be times when this is said as a final resort for example 'we have no appointment today, go to A&E' or a safety net 'if symptoms get worse, go to A&E' which may not be interpreted by patients as intended.
3. Bring certain aspects of the experience of A&E that people value to primary care. Patients reported that at A&E they felt that they were seen by experts, had tests

done and felt more involved in their care (See Findings 1.4.2, Sections 5.8, 5.9, 5.10, 5.11, 5.12). In line with the CLCCG's Better Care, Closer to Home strategy (2012-2015), it may be possible to bring some of these aspects to primary care wherever possible. For example:

a. Where practical investigations should take place in primary care rather than in the hospitals. If patients do not get referred to hospitals for tests but are able to have tests within primary care, this may improve the perception of primary care as expert providers. Also, it could at some point be possible for patients to do some tests by themselves at home, e.g. urine tests (see section 5.6).This may be able to reduce unnecessary visits to the GP as well as A&E.
b. Inform patients more about GPs' Special Interests. Use these to rationalise appointments so patients feel they are seen by an expert. If possible refer patients to other GPs who have a particular expertise.
c. Every effort should be made to involve patients in their care so that they do not feel more involved in their care at A&E than at their GP practice.

4. A minority of patients are unhappy with their relationship with their regular GP (See Findings 1.4.3). This could be caused by some poor clinical practice or poor communication. For some patients it may be better to change GP practice.

   a. Ensure all patients know how to change GP and are aware that this will have no consequences for their care. This information should be visible in GP waiting rooms and cascaded through community groups. This project found that a substantial minority (20%) did not know how to change their GP practice(see Section 5.20).
   b. Ensure wherever possible that patients with language needs have easy access to an interpreter. Language line and face to face interpreting services already exist and should be utilised systematically.
   c. Reception staff should be trained in working with a diverse community and particularly in working with people whose first language is not English and/or people who suffer from anxiety or mental distress (see Findings 1.4.3 and Section 5.22).

5. Further research should be carried out with patients who attend A&E repeatedly to find out why they do so and what would make them decrease the repeated use of A&E.
6. Improve referrals to community organisations and to community run health programmes (such as the community champions, health trainers, Wellwatch, Diabetes Mentoring Scheme, Expert Patient Programme, Diabetes Prevention Scheme, mental wellbeing programme and other health & wellbeing services, etc) as these may be able to support patients to stay well and to understand how to access NHS services appropriately.

7. Provide workshops for GPs and Practice staff on what local community organisations are providing that can support patients.

1.5.3. Recommendations for Changes in A&E and Urgent Care Centres

1. When patients visit A&E inappropriately their experience should be as similar as possible to attending a GP practice (see Findings 1.4.2 and Section 5.5 and 5.8). For example:

   a. Patients could be told that they cannot be seen at A&E and have an appointment booked for them with a GP where they can be seen with 4 hours.
   b. Patients could be seen by a GP at A&E who would follow the same processes as a GP based in the community (same access to tests etc).
   c. Ensure that when a patient goes to A&E the staff have access to the patient's records to ensure that no unnecessary tests are done or repeated to avoid giving patients the impression that an examination at A&E is more thorough.

1.5.4. Recommendations for Changes in Community Provision

1. Community organisations could be involved in delivering a community education programme that raises awareness within different BME communities about when to utilise which NHS services and what the different services provide. The community education programme should also engender a sense of responsibility with communities in relation to how and which services they access and the cost of utilising emergency and urgent care as opposed to GP and other services. Such a programme could be delivered alongside other community health education programmes such as ESOL for Health or the Expert Patient programme.
2. Make some provision for community health advocacy which could support patients who have unresolved issues with their primary care in order to ensure they are able to access appropriate primary care and do not attend A&E as a default.
3. Provide a structured health education programme targeting people who do not speak English that can support people to manage their long term conditions and teach them how to best manage their appointments with their GP, book double appointments if needed, and make complaints. This could be done in the Expert Patient model with sessions run in Arabic, Somali and Bengali, and in the ESOL for Health model to support people improve their English at the same time.

1.5.5. Recommendation for changes in the collection of Ethnicity data

The BME communities constitute 38.4% of the population in Westminster but 48.6% of the sum total of all A & E attendances. Individual groups of 'categorised' BME communities do not represent high A&E usage compared to the different white categories except for the category 'Any other ethnic group.' The 'Any other ethnic

group' constitutes 11.1% of the local population and yet has 26% attending A&E (see Section 4).

1. NHS Trusts delivering A&E and urgent care services for the population of Westminster have a contractual obligation to collect ethnicity data. This needs to be done to a higher standard in order to identify who the 26% attending A&E are in order to target the community education programme towards these groups. To achieve this, it is likely that more ethnicity categories would have to be used that are not in line with the categories used by the ONS such as Arab and Somali. For example the African category realistically does not provide very useful data as Africa is a very large continent with many different countries, ethnicities, cultures and languages. Effective targeting will only be possible if the data collected can identify more precisely the ethnicity of the patients (see Section 3.2 where participants were asked to describe their ethnicity).

2. Introduction

This project has enabled people from deprived communities to say how they use healthcare, particularly A&E and GP services and what changes would have to be made before they change their pattern of use to fit a model considered more desirable. The project emphasises the BME Health Forum's commitment to working with communities in collaboration and the project was co-produced with community groups at every stage including formulating ideas and recommendations for the report.

The BME Health Forum's core principles of co-production, collaboration, being open to the community, clarity, community research, capacity building and more were encapsulated in how this project was undertaken. Part of the strengths of the BME Health Forum is enabling capacity building within small community organisations. In this project this was achieved via, the positive 'knock-on' effects of volunteer training which lead to volunteers and staff learning more about the NHS and what to expect from GPs and A&E. There was also increased awareness of costs of services and appropriateness of use. In some instances organisations were able to learn new referral routes and also to collaborate more with each other.

The Unscheduled Care Insight project was funded by the NHS Central London Clinical Commissioning Group (CCG).

2.1. Aims of the project

The project's primary aim was to gather insight into the patterns of unscheduled care utilisation in deprived communities. The project achieved the following outcomes:

2.2.1. Outcomes

- A better understanding about the circumstances and the reasons why people from deprived communities access emergency services and receive unscheduled care
- Local voluntary organisations gained knowledge, skills and capacity to support their clients to use NHS services appropriately
- Volunteers from the local community received training and experience in community research and gained an understanding about how to use the NHS appropriately
- Feedback has been given to commissioners and providers about the findings of the project with recommendations aiming to improve care for people from deprived communities.

3. Methodology

The Health Forum used an open recruitment process to recruit 5 community organisations that work with clients from deprived communities in the area covered by NHS Central London CCG to deliver the project.

The organisations were expected to:

- Recruit a minimum of 4 bilingual volunteers per organisation
- Provide CRB checks for volunteers
- Dedicate a member of staff to supervise and support volunteers
- Allow the dedicated member of staff to attend training in the aims of the project and a monthly steering group meeting to discuss the progress of the project and feedback on the final report.
- Co-produce questionnaires with the other organisations and NHS Central London CCG
- Recruit 25 research participants per organisation who are registered with a GP covered by NHS Central London CCG or who are not registered with a GP at all but live in the same area and who either have long term conditions and/or are frequent users of A&E services.
- Provide the BME Health Forum with the completed questionnaires in a timely manner
- Co-produce the report with the other organisations and CCG

The 5 selected organisations were Abbey Community Centre, Healthier Life 4 You, Marylebone Bangladesh Society, Midaye and Westminster MIND.

The BME Health Forum's role was to:

- Train staff and volunteers
- Provide ongoing support for staff and volunteers
- Co-produce questionnaires with the organisations and the CCG
- Input data from questionnaires
- Analyse the results
- Co-produce this report with the organisations and the CCG

The following selection criteria was used to recruit participants to take part in the research:

- All the participants had to be registered with a GP within the NHS Central London CCG (see Appendix 1 for details) OR
- Live within the NHS Central London CCG catchment area and not registered with a GP at all

Additionally, the participants had to meet at least one of the following criteria:

- Patients with long term conditions (LTC) such as diabetes, heart disease etc
- Parents of children with LTC (e.g. asthma etc)
- Adults without long term conditions who are frequent users of A&E (e.g. 3 times in the last 2 years)
- Parents of children without long term conditions who are frequent users of A&E (e.g. 3 times in the last 2 years)

As the project was focusing on involving clients from deprived communities it was anticipated that a minimum of 80% of clients would be from BME groups and a minimum of 75% would not be in full employment. This was in fact case with over 87% of the participants being from BME communities and 83 % being unemployed.

3.1. Accountability

Organisations reported to the BME Health Forum project lead every month on how the project was progressing including data on the number of clients being interviewed. This took place mainly at monthly steering group meetings, and sometimes via phone or email. The Steering group comprised the BME Health Forum staff, CCG staff and lead project staff and volunteers form the 5 organisations. Additionally, organisations reported to the BME Health Forum project lead if difficulties arose, such as volunteers leaving.

3.2. Demography

The research part of the project was based on 125 questionnaire (of 76 questions) interviews. There were also 6 additional interviews held with participants to acquire further information.

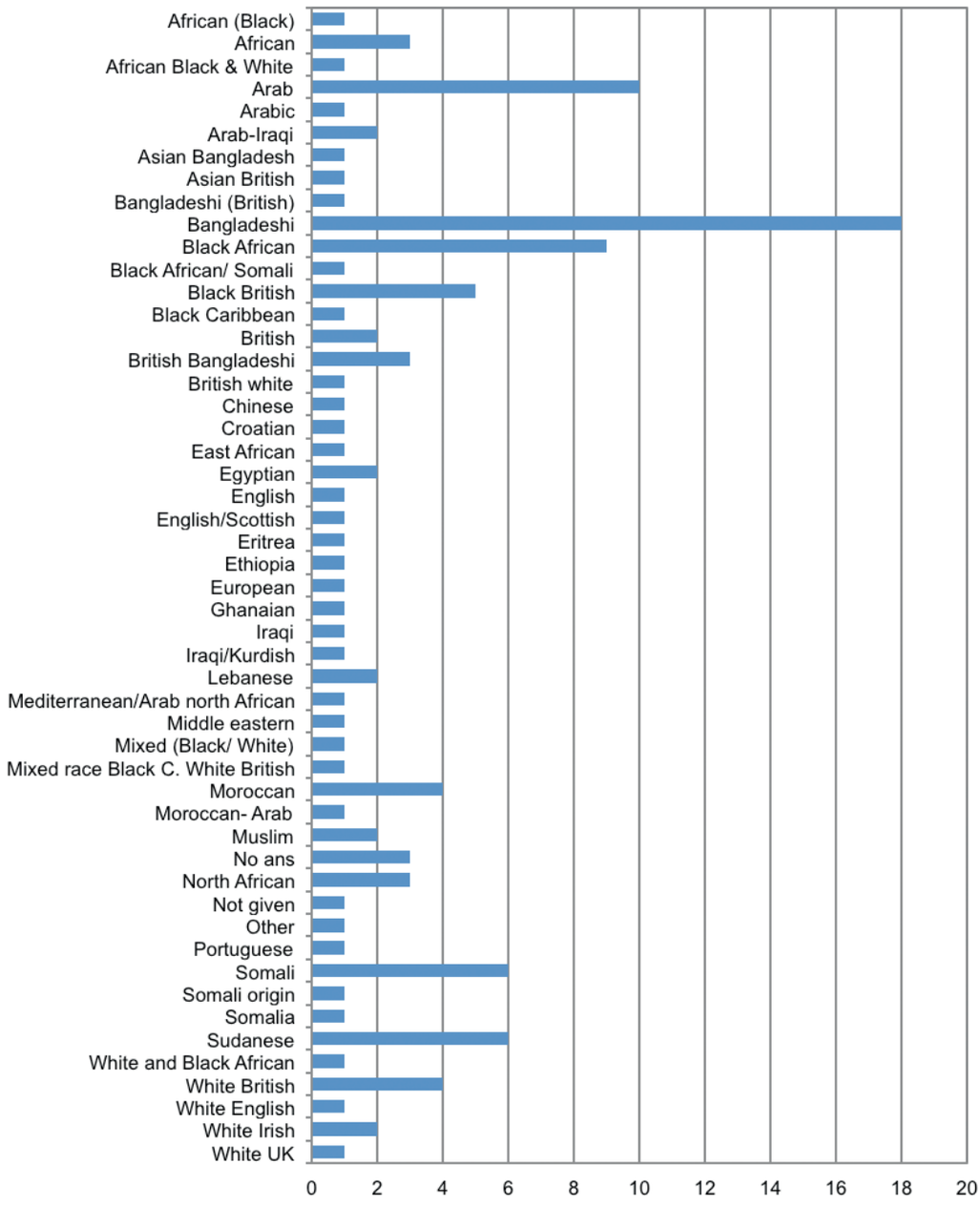
Of the 131 participants, only 68% people were fluent in English. Sixty seven people responded to the question about using an interpreter with 30% of those having used an interpreter.

Most of the participants (81%) were female and 73% had long term conditions (LTC). Half the participants had children under 18, while 19% had children under 18 years old with LTCs. Most of the participants (83%) were unemployed and of those who were employed, half were in part-time work. Of the unemployed women, 20% had children with LTCs.

The largest age group who took part in the survey were people in their forties (29%) with 25% in their thirties and 17% in their fifties. Twelve percent were in their twenties, 11% in their sixties with 5% in their seventies and just 1% in their eighties.

Five participants were not registered with a GP.

Chart 1: Ethnicity Chart



One hundred and eighteen responded to the ethnicity question. Participants were asked to describe their ethnicity. It is evident that there were a lot of different characterisations of how people saw their ethnicity. In terms of numbers of groups, there were 10 people who saw themselves as 'Arab', one as 'Arabic' and 2 as 'Arab-Iraqi'. Eighteen participants saw themselves as 'Bangladeshi' and 3 as 'British Bangladeshi,' there is noticeably a diversity at how people saw themselves in terms of 'Black', 'African (Black)', 'Somali', and 'Black African/Somali'. In total 87% of the participants were from the BME communities.

4. Background

The table below shows the utilisation of A&E by people living, working or visiting Westminster during 2012/2013 according to ethnicity. The data is based on A&E attendances by registered GP patients in 2012/2013 which includes people who are not resident within the area. The data on residents is based on the 2011 Census data. Ethnicity recording in the NHS is poor at 66% in Westminster.

NHS Ethnicity Coding	Numbers attending A&E 2012/13	% of known ethnicity attending A&E 2012/13	% ethnicity by LA resident Population 2011
British (White)	17,395	28.6%	35.2%
Irish (White)	1,078	1.8%	2.3%
Any other White background	12,700	21%	24.2%
White and Black Caribbean (Mixed)	210	0.4%	0.9%
White and Black African (Mixed)	182	0.3%	0.9%
White and Asian (Mixed)	202	0.3%	1.6%
Any other Mixed background	847	1.4%	1.8%
Indian (Asian or Asian British)	1,103	1.8%	3.3%
Pakistani (Asian or Asian British)	512	0.8%	1.1%
Bangladeshi (Asian or Asian British)	1,458	2.4%	2.9%
Any other Asian background	2,362	3.9%	4.6%
Caribbean (Black or Black British)	1,748	2.9%	2.0%
African (Black or Black British)	2,719	4.5%	4.2%
Any other Black background	1,622	2.7%	1.3%
Chinese (other ethnic group)	728	1.2%	2.7%
Any other ethnic group	15,771	26%	11.1%
Total Recorded	60,637	100%	100%
No ethnicity recorded	14,498		
Grand Total	75,135		

Data source: SUS (Secondary User Service) Westminster PCT data for 2012/2013 covering A&E attendances. 2011 Census from ONS on ethnicity by LA for population ethnicity.

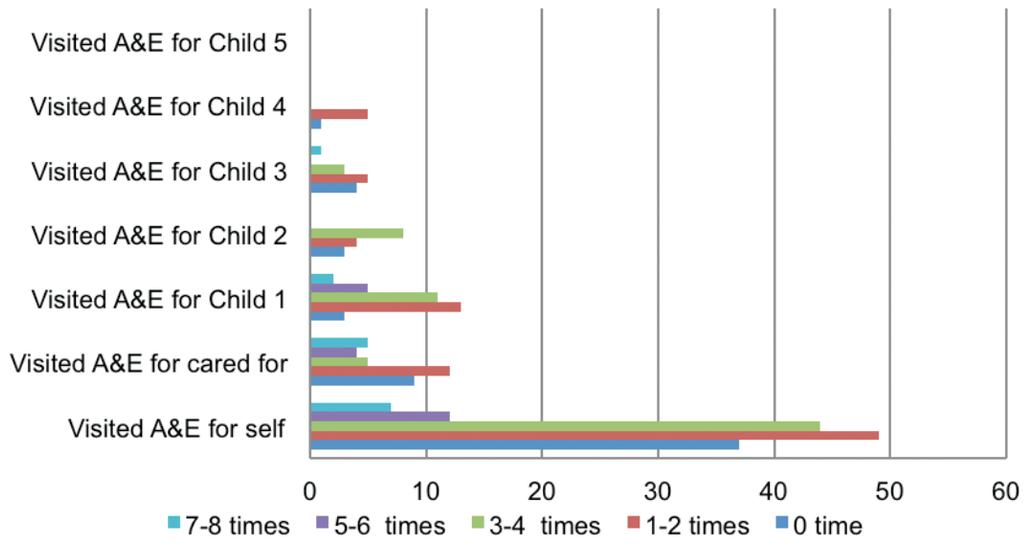
It is worth noting that attendance by BME groups is higher relative to their population than the White groups. In 2011, British (White), Irish (White) and 'Any other White background' made up 61.7% of the Local Authority population in Westminster while they made up a total of 51.4% of those who used A&E in 2012/13.

The BME communities constitute 38.4% of the population in Westminster but 48.6% of the sum total of all A&E attendances. Individual groups of 'categorised' BME communities do not represent high A&E usage compared to the different white categories except for the category 'Any other ethnic group.' The 'Any other ethnic group' constitutes 11.1% of the local population and yet has 26% attending A&E. Clearly, this requires further investigation.

5. Key Findings

5.1. Visiting A&E for Self, children and Cared For

Chart 2: Visiting A&E for Self, Cared For or Children



There was a fairly high number of visits for self to A&E. Forty nine people (44%) went to A & E one to two times in 2 years, 44 (39%) people went 3 to 4 times in 2 yrs, 12 (10%) people went 5 to 6 times in 2 yrs and 7 (6%) people went 7 to 8 times. Over a period of 2 years 112 of the adult participants had accessed A & E services.

Quite a high number of carers took the person they Care For to A&E. Out of the 36 carers, 26 (72%) took their Cared For to A&E between 1 to 2 times and 7-8 times in 2 yrs.

In the past two years there were as many as 252 visits by the participants in this survey (includes adults, cared for and children) to A&E over two times. 88 (34%) people visited A&E between 1-2 times, 71(28%) went between 3-4 times, 21(8%) went between 5-6 times and 15 (5%) went between 7-8 times in the two year period. The qualitative data backs this up with many of the participants saying that if they needed urgent care they would go to hospital. As many as 69 (61%) participants stated in the qualitative data that they would use A&E services if in need of urgent care.

Quotes from qualitative data:

'I would firstly see if my Dr is available if not I would go to A&E, usually I see my Dr'

'I would go to A&E because I cannot get an appointment with my GP soon enough'

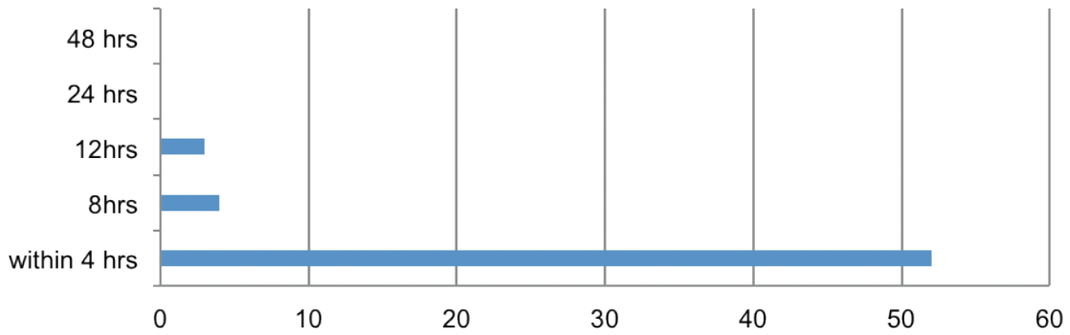
'I will call the ambulance or go to hospital'

'I would visit A&E as I would be seen that day'

As many as 43 (37%) people out of 117 had a hospital admission due to a medical emergency with only 8 feeling it could have been avoided.

5.2. How quickly patient felt they needed to be seen by their GP

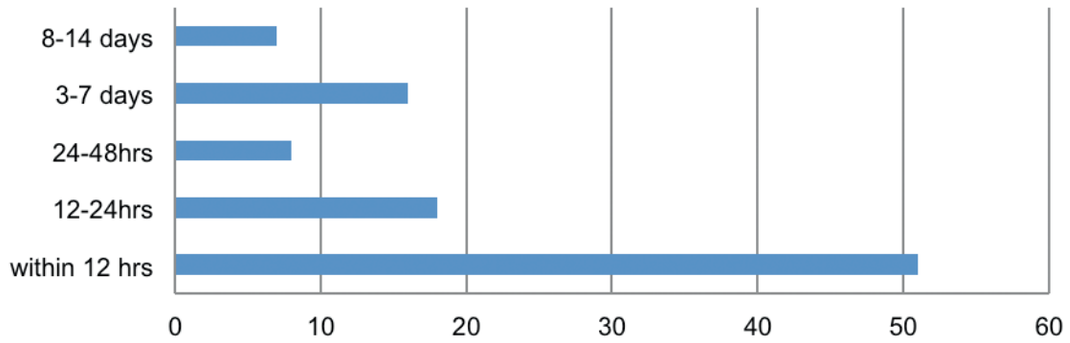
Chart 3: How quickly you needed to be seen?



Of the participants who responded to the question regarding how quickly they felt they needed to be seen 88% felt that they needed to see a GP within 4 hours. This would explain the high number of participants utilising A&E over a period of 2 years.

5.3. How quickly patients were able to see their GPs

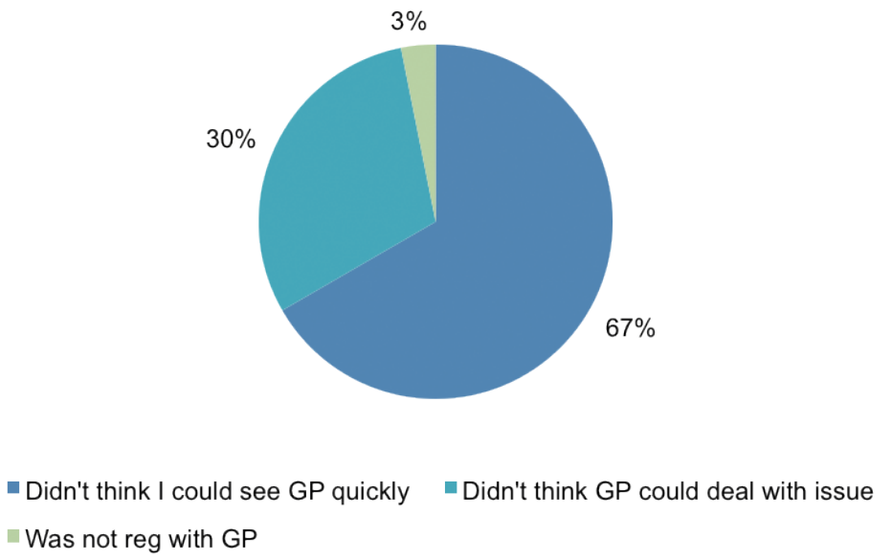
Chart 4: How quickly have you been able to see your GP?



Just over 50% of the participants were able to see the GP within 12 hours. The longest wait was by 7 people who had to wait between 8-14 days to see a GP when they needed to see one urgently.

5.4. Reasons for not seeing GP before going to A&E

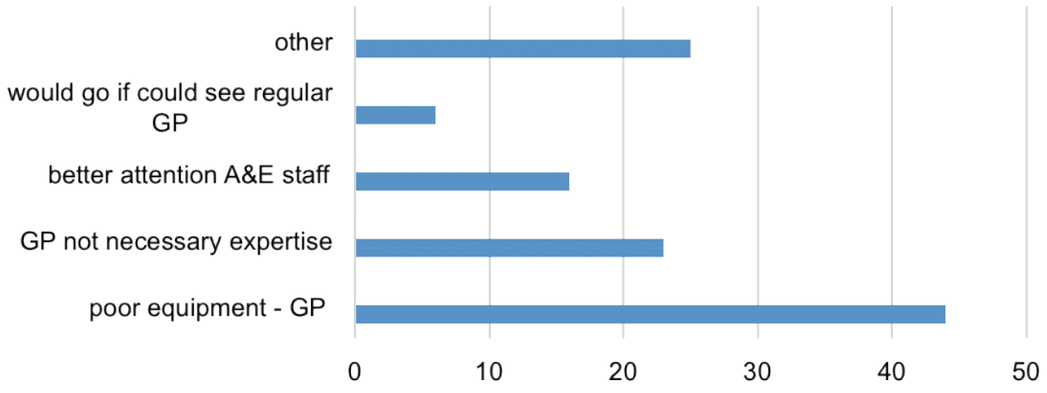
Chart 5: Why patient didn't attempt to see GP before A&E?



Participants mostly went to A&E before attempting to see their GP because they felt they would not be able to see their GP quickly enough (this could be because their practice was closed). This ties in with the earlier chart where 50% of the participants were able to see their GP within 12 hours. 30% indicated that they did not feel their GP could deal with their issues and went straight to A&E.

5.5. Why patients felt GP would not be able to deal with the problem?

Chart 6: Why your GP practice would not be able to deal with your problem?



39% of the participants felt their GPs would not be able to deal with their problems mostly due to what they perceived to be lack of 'necessary equipment' at the surgery, compared to A&E and 20% felt that their GPs did not have the 'necessary expertise. Additionally, 14% felt that the attention was better at A&E and 22% who

cited 'other' reasons talked about difficulty in getting appointments with their GP or the surgery being closed. Below are some of the participants' views:

'I felt I needed to be seen as quick as possible'

'surgery was closed when I had pain'

'the GP will say to go to hospital'

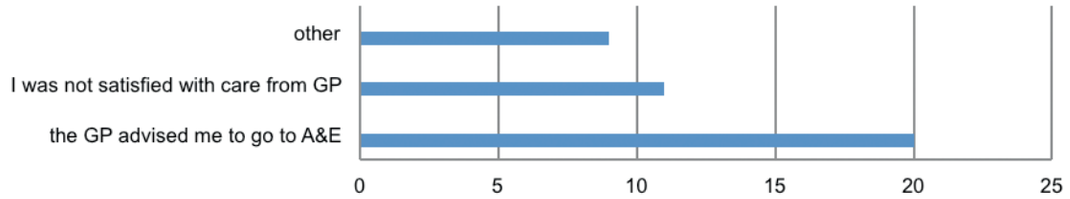
'there is no available appointments, even if I get an appointment my GP does not give me enough time to explain my health condition'

'I phoned and the GP told me to go to A&E'

'A&E are very quick'

5.6. Why patient still went to A&E after seeing GP?

Chart 7: After seeing your GP why did you still feel you needed A&E?



It is evident that a high number of participants were advised to go to A&E by their GPs. Of the 40 participants who responded to this question 50% of them said their GP advised them to go to A&E. Additionally, 27% were not satisfied with the care they received from their GP and stated this as their reason for still going to A&E after seeing their GP. 22% of the participants cited 'other' reasons for still going to A&E and 12.5% stated that it was difficult to get appointments with the GP. Some of the participants' views are noted below:

'wanted more care and attention'

'I felt my medication was unsuitable'

'I could not get an appointment with my GP'

'got more pain after seeing GP even after taking prescription'

'went to GP one day and pain was worse next day so decided to go to A&E'

'I spoke to my GP about the pain and he advised me to go A&E'

'sometimes if condition worsens I feel that GP surgery doesn't seem to check thoroughly as hospitals do.'

When asked what would make patients behave differently (Q 'What would make you do something different next time? (that is go to your GP rather than A&E?)), the main barriers to change were seen to be unavailability of urgent appointments and opening times. Patients were not aware that they had any other option besides A&E when the surgery was shut:

'If my GP survey was open or if he came quickly to my home then I would not go A&E'

'If I can see the GP urgently if I have more trust that the GP would treat my child quickly'

'If my GP is open and agree to give me immediate appointment I will see him'

'Go to GP if opened night time hours'

'Opening time- may be after 6pm and during the weekend'

'It was a weekend and the GP was closed. But I have a problem on a week day I will contact my GP'

'Sickness come at nights suddenly when GPs are closed. I have no option then go to A&E'

'I don't know. GPs aren't open Saturday/Sunday so I need to go to A&E'

'To make an appointment available any time, I mean during working hours not only 8.45am'

Other responses related to the availability of expertise, examinations, tests and relationships:

'Have much more understanding and expertise due to the problem I had'

'More time from GP, more understanding and listening'

'I rather go to A&E because if I need x ray they do it on the spot'

'GP should be more professional and check me correctly and listen to my problem rather than just conclude with 2 paracetamol solution!'

Other suggestions included:

'Do the urine test at home and if there is an infection I will go the GP immediately'

Some patients made it clear that no change would make them go to the GP instead of A&E.

'No'

'Nothing'

'If it's serious I would always go hospital'.

5.7. Referral to A&E

A fairly high number of Healthcare Professionals advised the participants to go to A&E. In 38% of the cases Healthcare professionals advised participants to go to A&E. Below are a variety of reasons why it was suggested that participants should go to A&E:

- Medical condition got worse and was advised to go hospital
- My baby was not breathing well so GP called 999 for us
- Always when I call to make an appointment been by receptionist that there is no appointment available and advise me to go to A&E
- I had a very high blood pressure and GP advised me to go to hospital
- When I had headache my GP advised me to go to A&E
- My GP advised me to go to A&E when I have had eye infection
- My doctor advised me to go to have tests done on my stomach
- My husband had breathing difficulty so my doctor called ambulance
- They haven't enough equipment (x-ray)
- I had chest pain & when I called my GP the advice me to go to A&E

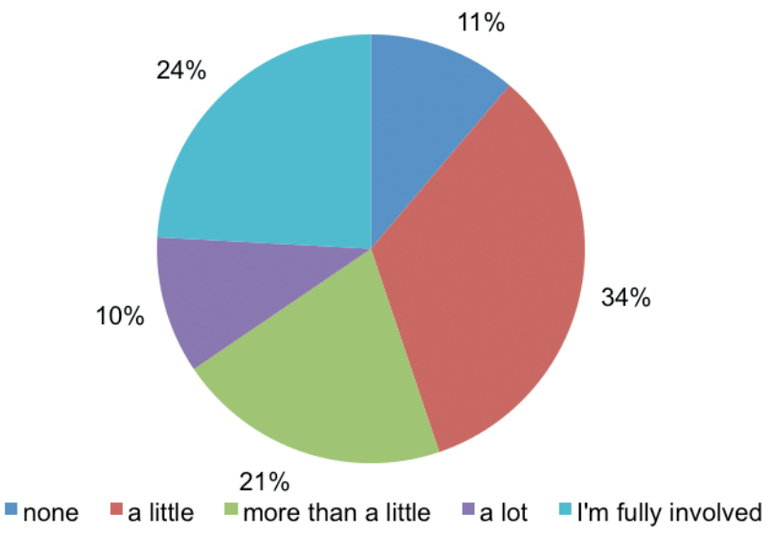
5.8. Which service do you feel provides a better service? Your GP Practice or A&E?

Of the 130 responses, 28% felt that their GP service was better whilst 57% preferred A&E with 11% stating that both services were good or the same. One did not like either service and 2 said 'not applicable.' Almost double the number of responses were in favour of A&E services over GP services.

Based on the data it is evident that A&E is largely seen as better equipped, easier to get scans and tests even though people often have to wait. The accessibility aspect seems an important concern for most participants with many as reported earlier feeling that the expertise of doctors at A&E is better.

5.9. How involved patients felt with their healthcare at the GP?

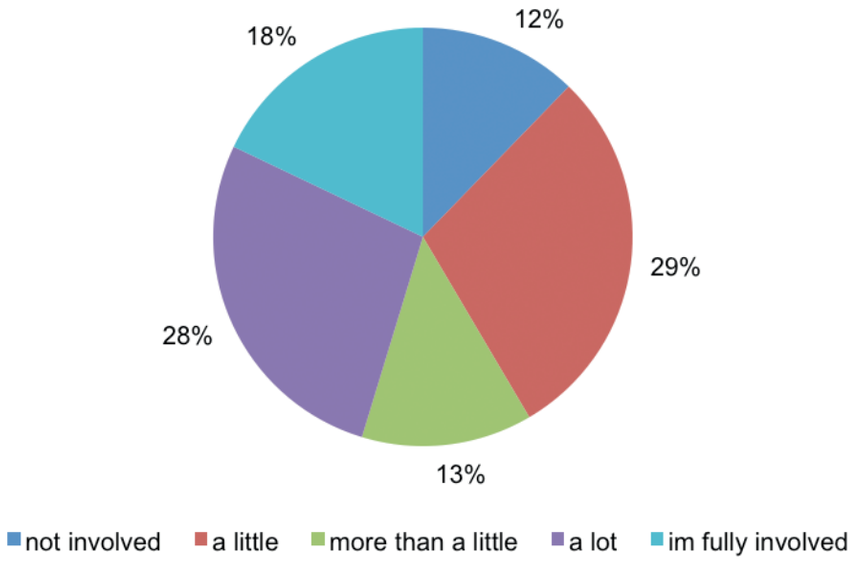
Chart 8: How involved do you feel you are in your healthcare when you go to your GP surgery?



Out of 116 participants 44% felt they were 'a little' or not involved in their healthcare, 21% felt 'more that a little' involved and 34% felt that they were involved 'a lot' or 'fully involved' in their healthcare at their GP surgery.

5.10. How involved patients felt with their healthcare at A&E?

Chart 9: How involved in your healthcare are you when you go to A&E?

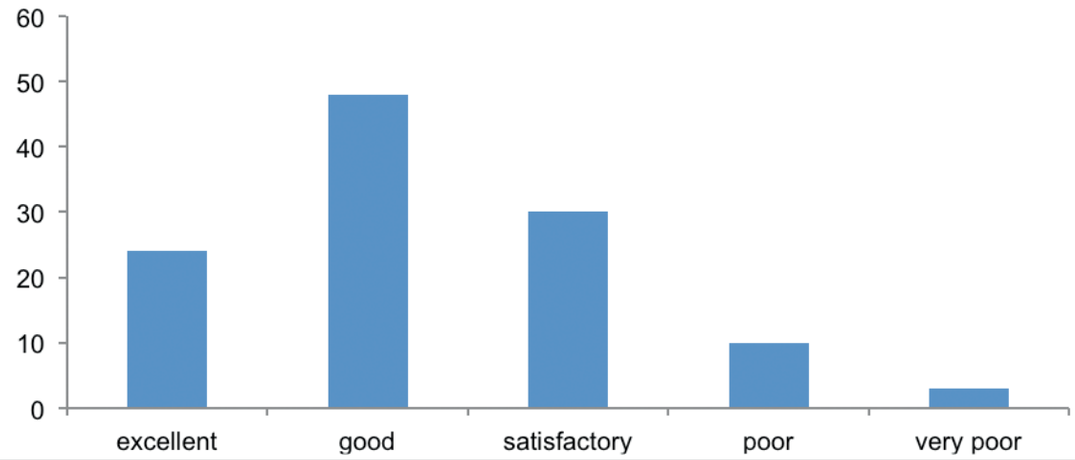


In terms of involvement in their healthcare when participants visited A&E out of 106 participants, 41% felt 'not involved' or 'a little' involved, 13% 'more than a little'

involved and 46% felt they were involved ‘a lot’ or ‘fully involved’. This indicates that participants felt more involved in their health care at A&E compared to the GP surgery.

5.11. Quality of healthcare at GP surgery

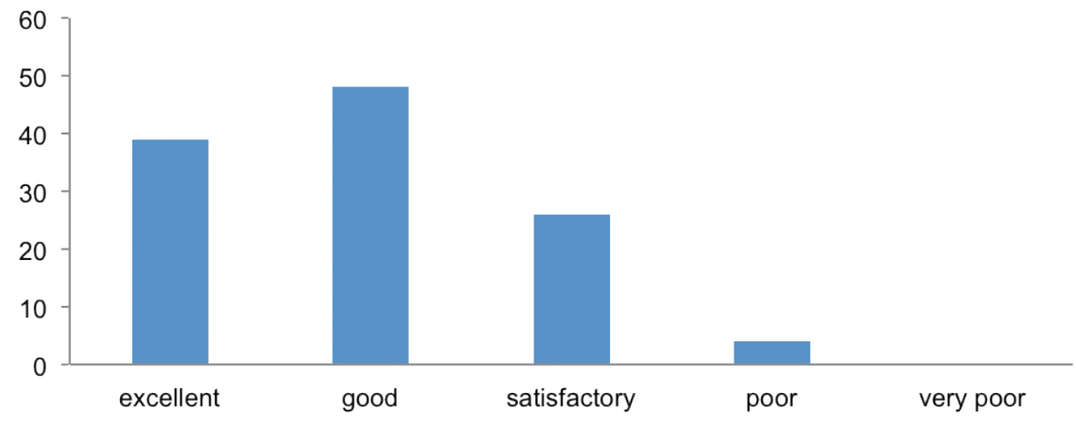
Chart 10: Do you feel you receive good quality healthcare when you go to your GP surgery?



When participants were able to see their GPs they had good satisfaction levels with regards to receiving the healthcare at the surgery. Out of 115 participants 63% felt it was ‘good’ or ‘excellent’, 26% felt that it was ‘satisfactory’ and 11% felt it was ‘poor’ or ‘very poor’.

5.12. Quality of healthcare at A&E

Chart 11: Do you feel you receive good quality healthcare at A&E?

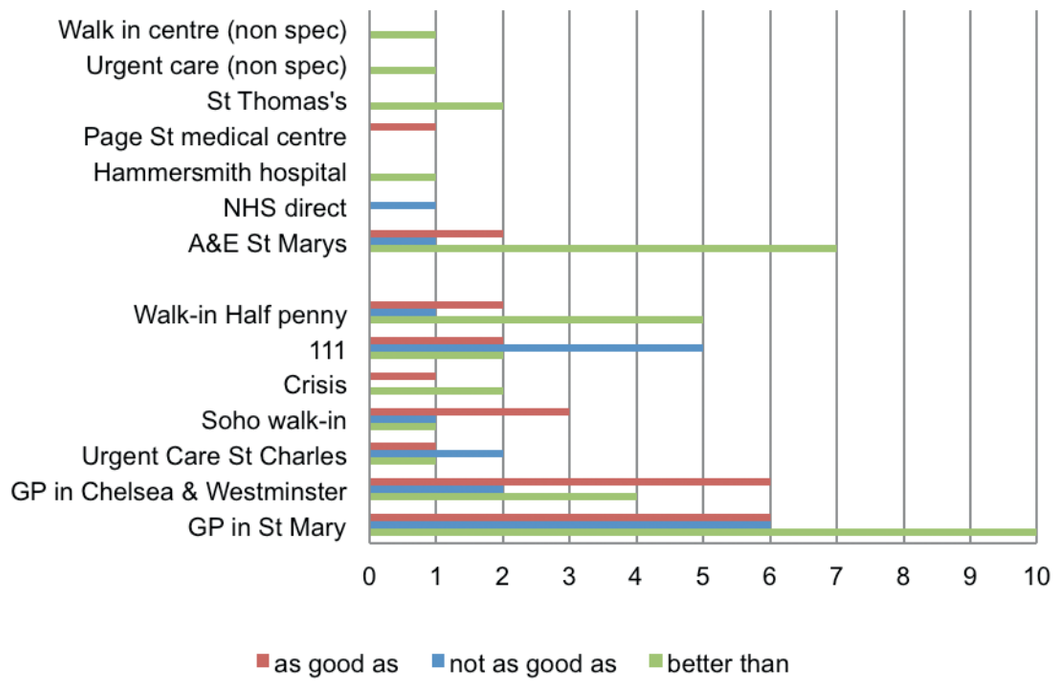


Out of 117 participants 74% felt that the quality of healthcare they received at A&E was ‘excellent’ or ‘good’, 22% felt it was satisfactory and 3% felt it was ‘poor’. This demonstrates a very good opinion and experience of healthcare at A&E and higher

than percentages for quality of healthcare experienced by people at their GP surgery.

5.13. Other services participants used for Urgent Care apart from GP

Chart 12: Listed services compared to GP?



Within the last 2 years 53 (47%) participants used services from the list below presented to them in the survey.

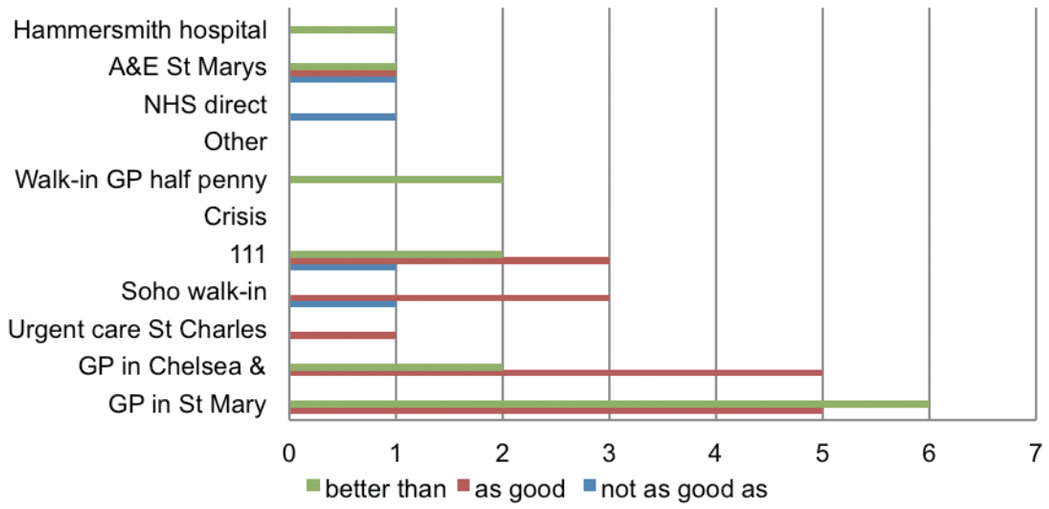
- GP situated within the A&E at St Mary's hospital (Urgent Care Centre)
- GP situated within the A&E at Chelsea and Westminster hospital (Urgent Care Centre)
- The urgent care centre at St Charles
- The walk in centre at Soho
- 111
- Crisis
- Walk in GP at Half Penny Steps
- Any other service providing urgent care

Twenty one (40%) of the 53 participants used the GP service at the Urgent Care Centre at St Mary's. The above services when compared to the GP surgeries were seen as 'better' than or 'as good as'. Only 9% used 111 with just over half stating that the service was 'not as good as' the GP service.

Only 7 people had contacted the Psychiatric Liaison Services (PLS) when in emotional distress out of 115 who answered this question and were happy with the PLS. Eighteen out of 19 people who rang 999 or 111 in emotional distress said that they were helpful. Only 16% called 111.

5.14. How other urgent care services are compared to A&E services?

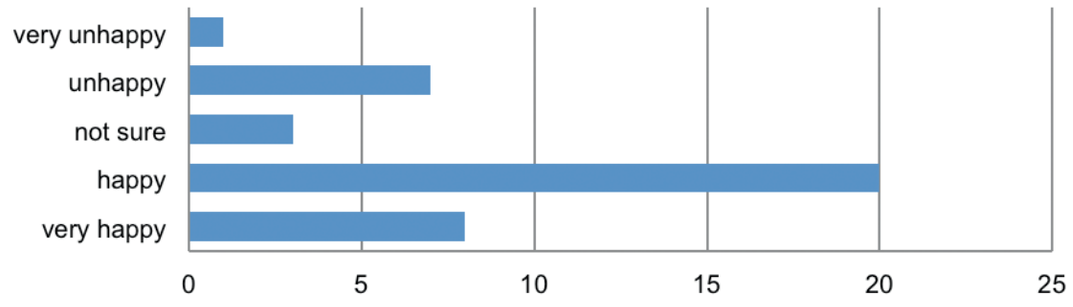
Chart 13: Service compared to A&E



Not many participants responded to the question about the above listed services compared to A&E. Most of the participants appeared to feel that the listed services were better than A&E services. Out of the 37 responses 40% stated that the services were 'better than' A&E, 49% said 'as good as' and 11% said that these services were 'not as good as' A&E.

5.15. Were patients happy with GP opening hours?

Chart 14: Happy with GP opening hours?

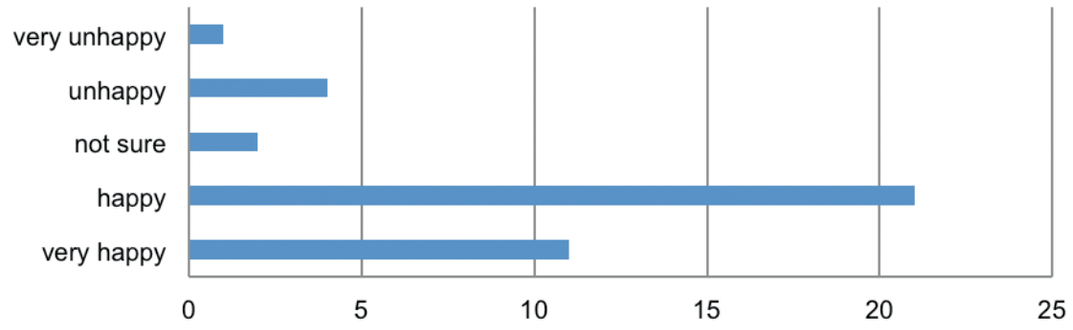


Overall, it appears that people are happy with GP opening hours, 70% of the participants out of 39 said they were 'happy' or 'very happy,' which seems at odds

considering that most of the data above shows that the participants struggled to get appointments on time when they needed to be seen urgently.

5.16. Were patients happy with their regular GP at the practice?

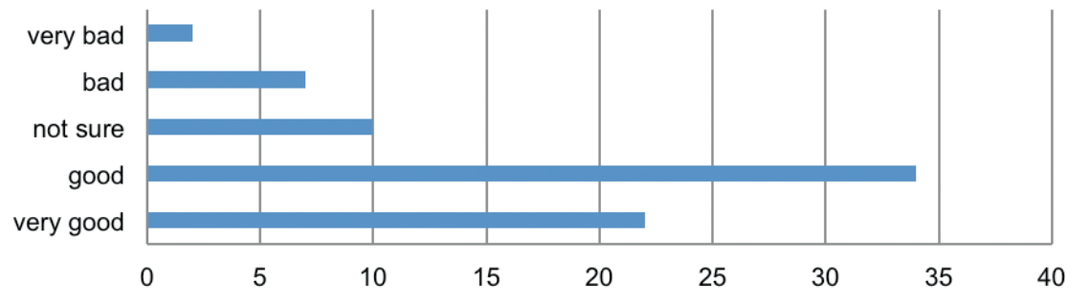
Chart 15: How happy are you with your regular GP at practice?



Thirty two (82%) participants out of the 39 who saw a regular GP stated that they were 'very happy' and 'happy' with their regular GP. A high level of satisfaction. Only 5 were 'unhappy' or 'very unhappy'. From the few individual interviews done with participants and from comments gathered via the questionnaire it would appear that when participants were able to see their regular GP they had a better experience at the surgery. Some people had GPs who could speak their language which helped immensely, and in general there was a sense of continuity with a regular GP.

5.17. Were the GPs good listeners?

Chart 16: Do you think your regular GP in your practice is a good listener?



It is clear from the above that out of 75 participants who responded that 75% found their regular GP to be a 'good' or 'very good' listener with 10 (13%) participant stating that they were 'not sure' and 12% stating that the GP was a 'bad' or 'very bad listener' . It would appear again that what participants like about their GPs is the continuity. However, as seen earlier having enough time with the GP, getting an appointment and concerns about expertise and equipment do affect the patient experience.

5.18. Discussing emotional well being with GP

Participants were asked if they felt that they could discuss issues relating to emotional well being with their GPs. A high number of people were happy to discuss emotional wellbeing with their GP. Quantitative data showed that as many 75 (64%) would discuss their emotional wellbeing compared to 43 (36%) who would not.

Qualitative responses showed that out of 44 responses, there were 35 (80%) positive responses about discussing emotional wellbeing with GPs, and 9 (20%) negative responses with patients quoting:

'I feel I can talk about anything'

'I think my GP is a very good listener and would try his best to help me'

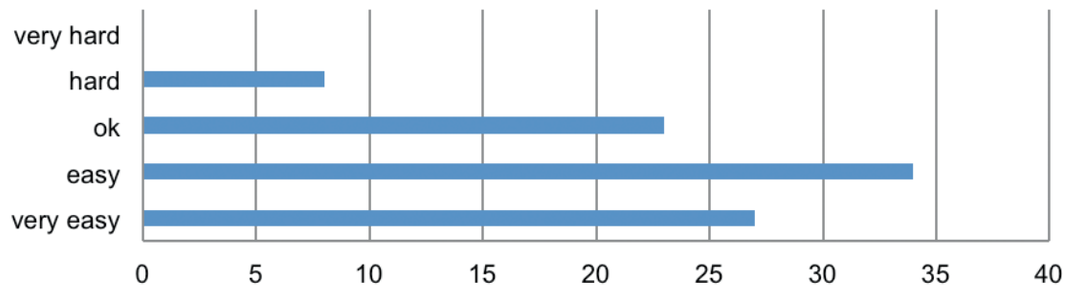
'she is very kind and understanding, she understands my language, I cannot speak English'

'yes I discussed with my GP my emotional feelings when I felt depressed'

'I have tried and he cut me off mid-sentence and prescribed anti-depressants'

5.19. Ease of registering with GP

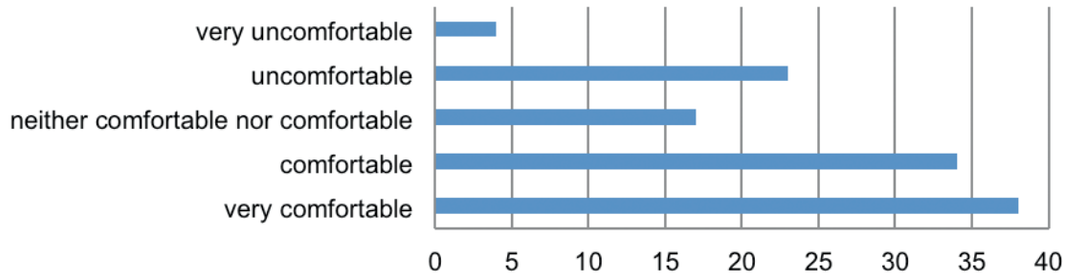
Chart 17: How easy was it to register with GP in last 5 years?



Registering with GP surgery does not appear to be a big challenge. Out of 92 participants as many as 84 (91%) found it 'very easy' 'easy' or 'ok' in terms of registering with a GP in the last 5 years.

5.20. Changing GP Practice

Chart 18: How comfortable would you feel changing your GP practice?

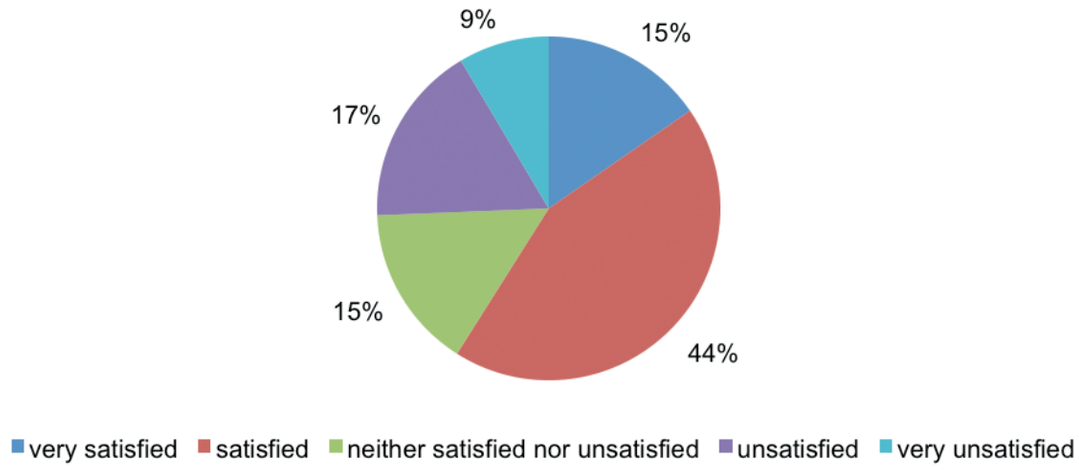


In terms of changing their GP practice most of the participants felt comfortable about doing this. Out of 116 participants 62% felt either 'very comfortable' or 'comfortable' with changing their GP practice and 23% felt 'uncomfortable' or 'very uncomfortable'.

Out of 125 participants 20% did not know how to change their GP practice.

5.21. Ease of booking appointments at GP surgery

Chart 19: How satisfied are you with the process of booking appointments at your GP surgery?



44% of 117 participants said that they are 'satisfied' with the process of booking appointments at the surgery and 15% were 'very satisfied'. Only 26 % were 'unsatisfied' and 'very unsatisfied'. Though a further 15% were 'neither satisfied nor unsatisfied'. Overall it would appear that 41% are dissatisfied with the process of booking an appointment. There were 37 negative comments out of 56 comments, and only 19 positive comments about how satisfied the participants were with the appointment booking process at their GP surgery with some examples of the comments made below.

'making calls is too expensive'

'because of not understanding English doctor doesn't give me appointment. Have to argue to get appointment'

'it is too difficult for me to speak to them because my English language is not good

'reception staff not attentive, they are very bad and rude and I don't like them'

5.22. Treatment of patients by GP surgery reception staff

Of the 115 participants who responded to how they were treated by reception staff 21% said that they were 'very satisfied', 37% 'satisfied', 22% were 'fairly satisfied' and 20% were 'unsatisfied' or 'very unsatisfied'. Participants were also asked to further comment on their experience of the surgery reception staff and of the 85 who responded 49% made negative comments with a substantial number of those who said that they were 'fairly satisfied' also making negative comments such as:

'the doctors treat the patient better than reception staff'

'the reception staff treat me like someone forced to help us'

'they need ethical course to know how to deal with patient'

'it depends what mood they are in, sometimes they don't answer the phone and sometimes they are rude'

'staff not very professional because of language'

Those who were 'very satisfied' or 'satisfied' made positive remarks about the reception staff such as:

'they try to understand my needs'

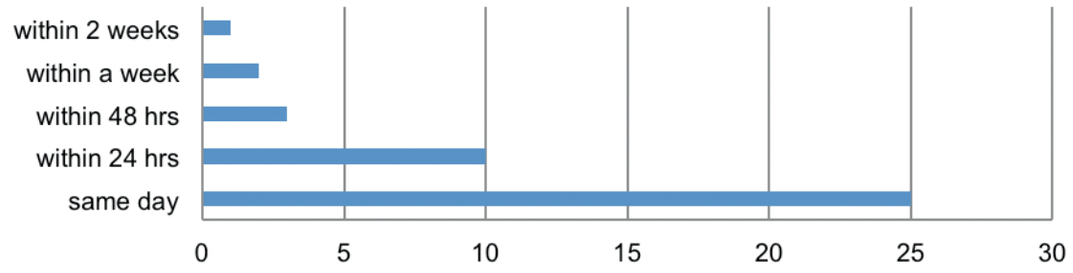
'excellent they make you feel good'

'I have always been able to get an appointment when needed one'

'I am satisfied with how reception staff treat me because I never have problems with them'

5.23. How quickly children under 5 years seen by GP

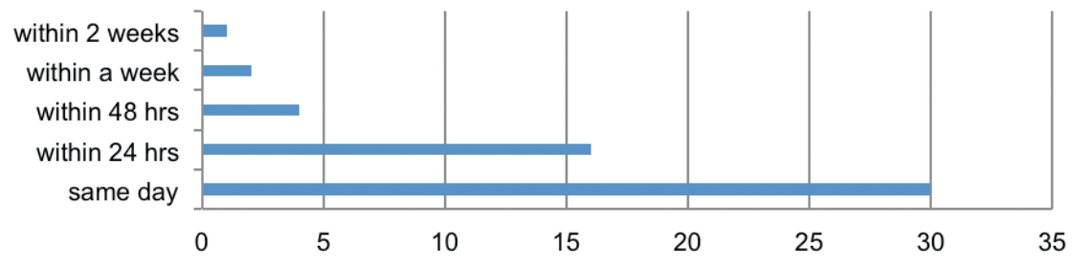
Chart 20: Children under 5 – how quickly seen by GP?



Children under 5 would be a high risk group and is reflected in how a large number of the participants were able to have their children seen quickly. Twenty five (63%) were seen on the same day and 10 (25%) within 24 hrs.

5.24. How quickly children over 5 years seen by GP

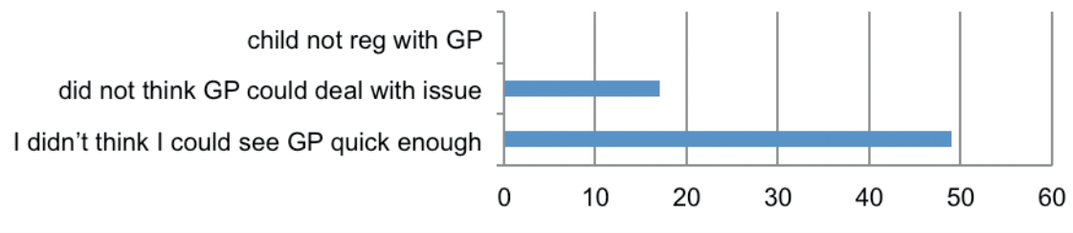
Chart 21: Children over 5, how quickly have you been able to see a GP?



The figures for children over 5 years old were also good in terms of being seen quickly by the GP. Thirty (60%) were seen the same day and 16 (31%) within 24 hours.

5.25. Reasons why parents did not take their child to GP first before A&E

Chart 22: Why did you not attempt to take the child to GP before going to A&E?

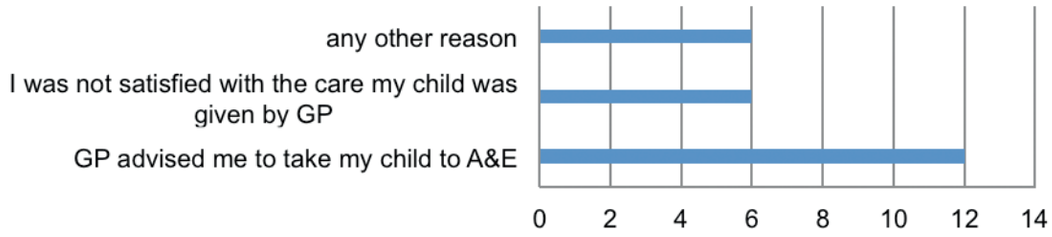


Even though it appears from the previous two charts that children are seen quickly, it appears from the above table that a lot of parents feel they would not be able to see

the GP quickly enough, in the instances they took their children to A&E first before seeing a GP. In addition 10 parents (after taking their child 2 times to A&E first) felt that the GP could not deal with the issue, and so they went straight to A&E.

5.26. Why did child go to A&E after seeing their GP?

Chart 23: If your child had seen a GP, why did he/she still have to go to A&E?



Of the 24 parents who responded to this question 50% were advised by their GP to take their child to A&E. Some other reasons cited with regards to why parents still took their children to A&E were as follows:

'because she needs to be seen by a professional'

'the GP said he was fine but he had a high temperature'

'GP closed at night'

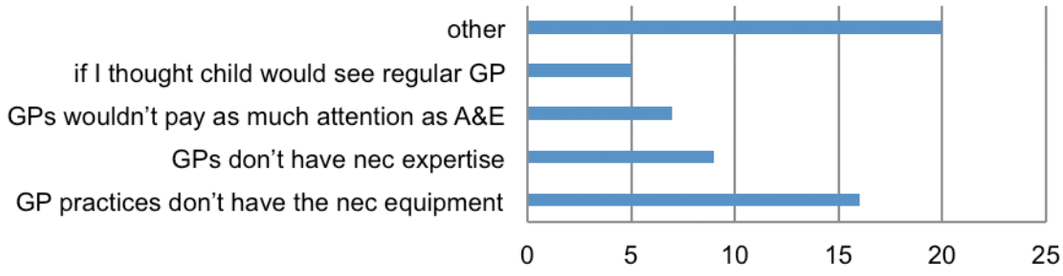
'the waiting time was too long to see my GP'

'did not take the issue seriously enough and refused me blood test for my daughter'

'because GPs do not have the necessary equipment'

5.27. Why did parents feel their GP practice could not deal with child's problem?

Chart 24: Why did you think your GP practice could not deal with child's problem?



It would appear that 28% of the parents were concerned about whether GPs have the necessary equipment, 15% of parents felt GPs didn't have the necessary expertise and 12% felt GPs wouldn't pay as much attention as A&E staff. Ten

parents said that the surgery was closed and hence they went to A&E. Seven mentioned that it was not possible to get appointments in time. Some of the other reasons were:

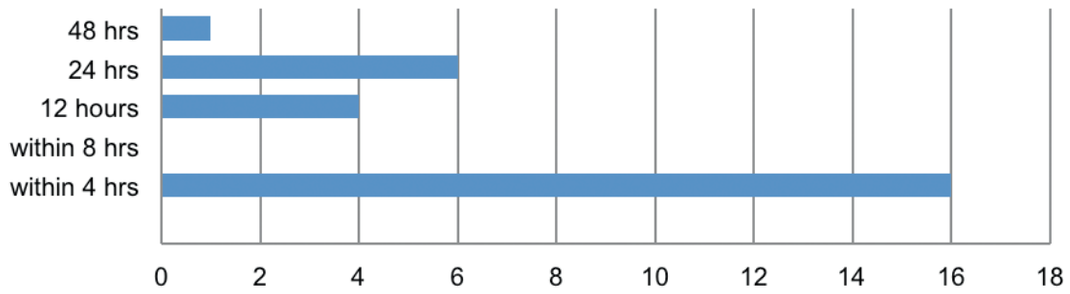
'the appointment system does not help, so if we need to see our GP urgently we have to wait between one to two day'

'there would have been no point. I would have had to take her to the GP surgery. Plus they don't have x-ray machine'

'they don't understand how serious issuses are or what the issue is'

5.28. How urgently have you been able to see a GP for your Cared For?

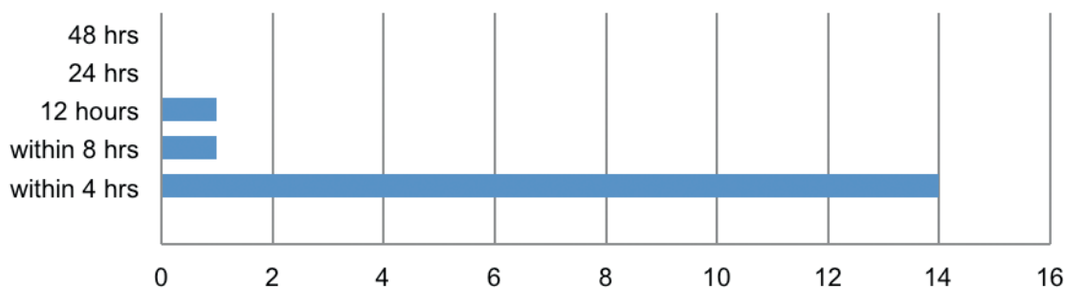
Chart 25: When person you care for has needed to see GP urgently, how quickly have you been seen?



Out of the 27 Carers responses, 60% said that they were able to see the GP for their Cared For within 4 hours when it was urgent and 37% between 12 and 24 hours.

5.29. How quickly did you feel the person you Cared For needed to be seen?

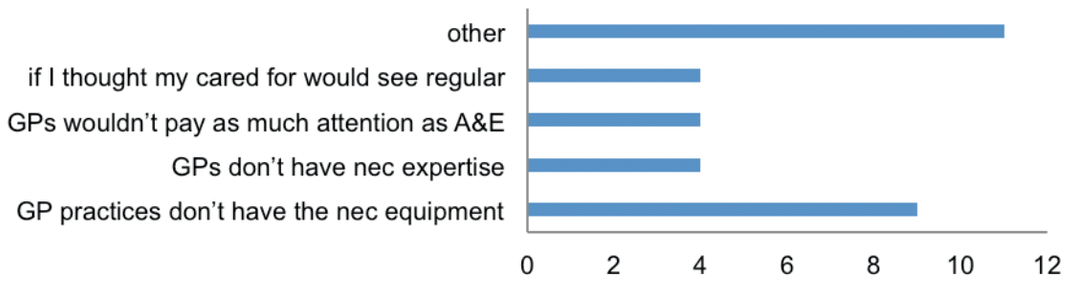
Chart 26: How quickly did you feel the person you care for need to be seen?



Out of 16 carers who responded 87.5% felt that their Cared For needed to be seen urgently within 4 hours.

5.30. Reasons you felt your GP would not be able to deal with the problems?

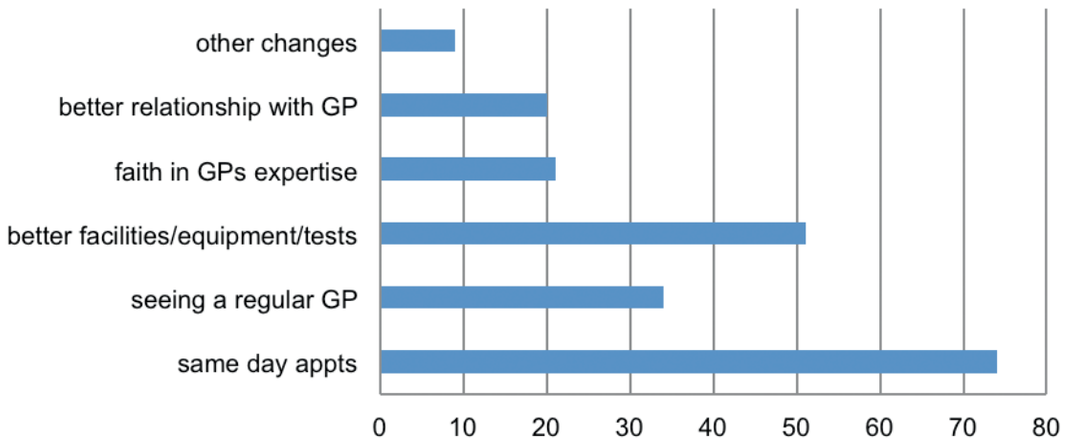
Chart 27: Why did you think your GP practice would not be able to deal with the problem?



Of the 32 responses 9 (28%) Carers felt that their GP surgery would not be able to deal with their Cared For's problems due to lack of necessary equipment at the surgery, 4 (12.5%) said that the GPs did not have the expertise and 11 (34%) said that the surgery was closed or they couldn't get an appointment.

5.31. What would make patients, parents and carers use GP instead of A&E?

Chart 28: Changes that would make you go to GP rather than A&E?



The above chart shows that over 74 (59%) out of 125 participants felt that if they could get 'same day appointments' they would go to their GP rather than A&E with 50 (40%) more willing to see a GP if there were better facilities and equipment at the surgery.

Qualitative data from this question yielded similar responses. The main barriers to change were seen to be unavailability of urgent appointments, opening times and expertise:

'Receptionist should be good and offer convenient times'

'Open 7 days a week'

'Evening open hours'

'Consultants within our GP surgery'

Other suggestions included:

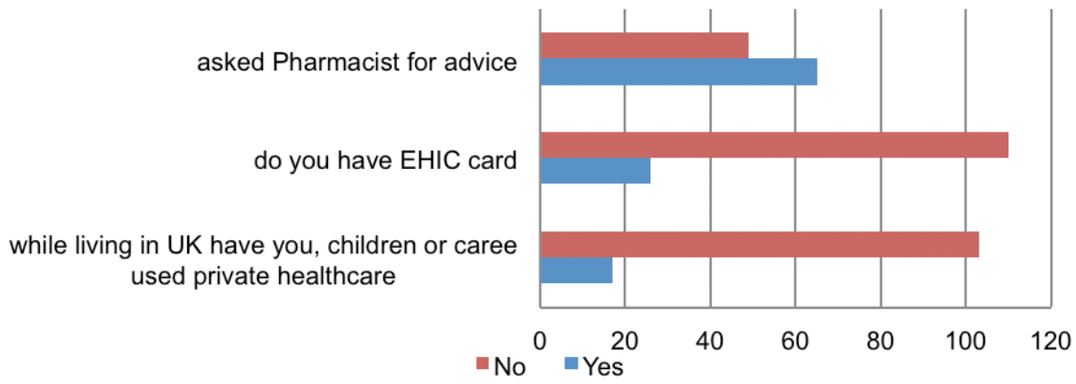
'Interpreting from the community from someone I can trust'

'Language support/community service at GP'

'Female doctors should be readily available'

5.32. Private tests, EHIC card and visits to Pharmacist

Chart 29: Private tests, EHIC card & Pharmacist



Asking the Pharmacist for advice

Within the last two years out of 114 participants 65 (57%) had asked a pharmacist for advice on a medical condition and 49 (42%) had not. Most people had gone to their pharmacist for minor illnesses like coughs, colds, skin conditions, eye infections, allergies, etc.

EHIC card

Out of the 125 participants 26 people (20%) said they had an EHIC card. Most people who had the card had not used it. One person had used it Italy at A&E and one when travelling to Cyprus.

Private healthcare

Out of 120 participants 17 (14%) have used private healthcare while living in UK in the past 2 years. Many of the people who had used private healthcare had used it

for things like Blood tests, and a few to see Somali doctors. The following are some of the reasons given for using private health care:

- For Doctors appointments and scans
- Wasn't sure of diagnosis given by hospital
- Blood Test
- My mother had taken me to Somali doctor in London about my skin condition
- Had traditional Somali medicine (herbs/leaves grounded for like medicine).

5.33. Other services used for LTCs or Urgent Care

It was interesting to note that of 129 responses to the question about 'other services used for LTCs or Urgent Care 13% of the participants used herbal treatments in addition to NHS services, 12% got support from community organisations, 11.6% relied on their faith for support and 11 % sought alternative treatments.

5.34. Additional Outcomes:

There were some unanticipated benefits for the participants of the project.

- Two of the organisations were able to work with 2 participants who were homeless in securing accommodation.
- Participants decided to get the EHIC card.
- The project was able to attract people in the community who were not previously in touch with or known to the community organisations.
- Participants were referred to other services such as the Expert Patient Programme, Women's Exercise, English Classes, Wellwatch, a carers group and Diabetic Mentoring.
- At a general level people's awareness of NHS services was improved as there were was better awareness such as making 'double appointments' with the GP and free NHS services.

6. Conclusion

This study is an extensive piece of work covering a variety of issues around how people use their GP and A&E services.

Throughout the process of the Unscheduled Care Insight Project it was apparent that it was important to be aware of 'cultural assumptions.' This included and includes generalisations about how people from different ethnic minorities may use healthcare. Statistics show that a high percentage of White British people used A&E services in 2012-13, and a higher percentage of BME communities used A&E (when all the ethnic groups were added together). However, the rates amongst the 'categorised' different ethnic groups were very similar to the White British group other than the 'other ethnic group' category.

With some improvements in equipment and ease of getting appointments at GP, more participants would be interested in using the GP surgery more than A&E. It is apparent from the project that there is a need for more 'education' for both GP's and community groups on the needs of the local population and appropriate use of NHS services respectively. Clearly health professionals refer people to A & E and it would be beneficial to interview GP's, nurses and reception staff to identify when and why these referrals are made.

In the study it is apparent that people's reaction to illness, particularly when it was a family member or cared for may have an impact on how they use health services. For example, they may have used A&E more if they were frightened or anxious about their own or a relative's condition.

In the course of this project it has also become clear that it is not just what GPs can do but community awareness of NHS services is just as important. This will be looked into more in the Recommendations section of the report. But essentially, based on the quantitative and qualitative better information sharing about the costs of NHS services such as an ambulance call out, appropriateness of usage, availability of information about services and alternative services, use of interpreters etc could lead to better usage of NHS services in a 'cost effective' way.

Over the past few years there has been a lot of Government interest in the Unscheduled Care issue, particularly in 2013. An article in the Guardian in 2013 by Andrew Hine, Head of Healthcare at KPMG looks as how the Minster for Health's plans to have longer GP opening hours will change the way GPs work, but also promotes the importance of how patients look at their use of healthcare and states that:

’Putting patients at the heart of a revamped NHS must always be the priority, but the changes involved are complex and require changed behaviour by both professionals and patients. We need an increasing range of clinicians to treat us differently in different places and using different technologies. And we as patients need to take our share of the responsibility of care. If these changes are made then the NHS will cope well with the pressures of ill health in a growing and ageing population. If not, it won’t.’ (Andrew Hine, UK Head of Healthcare for KMPG)

http://www.kpmg.com/uk/en/industry/healthcare/pages/default.aspx

7. Recommendations

7.1. Recommendations for changes in Primary Care

Most patients report having positive relationships with their regular GPs (See Findings 1.4.1). Most patients felt their regular GPs were good listeners and provided a good service. This is the foundation for the other recommendations.

1. Findings have shown that those who feel that they need urgent care want to be seen quickly and that they have little awareness of other options besides A&E when their practice is closed. Overwhelmingly, the most significant reason for attending A&E rather than a GP practice was the speed with which people could be seen. (See Findings 1.4.4 &1.4.5). To rectify this we make the following recommendations based on the respondents' suggestions (See sections 5.6 and 5.31):

    a. A guarantee to patients that when they have an urgent need they can be seen by a GP in a GP surgery, Urgent Care Centre, Walk-in Centre or Out Of Hours service within 4 hours.
    b. Pilot drop in clinics that are open late in the evening (e.g. until midnight)
    c. Raise awareness on the availability of Out Of Hours services through direct conversations with patients as this group of patients do not access information though mainstream publicity such as GP practice websites.
    d. Ensure every GP practice has an effective and consistent appointments system for seeing urgent cases, particularly children and older people within 4 hours during their opening hours.

2. Work with health professionals about when it is suitable to advise patients to go to A&E. Many patients reported that they were advised to go to A&E by GPs but also by other staff such as pharmacists or receptionists. (See Findings 1.4.5 and Sections 5.6, 5.7, 5.32). While this may often be the correct advice, there may be times when this is said as a final resort for example 'we have no appointment today, go to A&E' or a safety net 'if symptoms get worse, go to A&E' which may not be interpreted by patients as intended.
3. Bring certain aspects of the experience of A&E that people value to primary care. Patients reported that at A&E they felt that they were seen by experts, had tests done and felt more involved in their care (See Findings 1.4.2, Sections 5.8, 5.9, 5.10, 5.11, 5.12). In line with the CLCCG's Better Care, Closer to Home strategy (2012-2015), it may be possible to bring some of these aspects to primary care wherever possible. For example:

    a. Where practical investigations should take place in primary care rather than in the hospitals. If patients do not get referred to hospitals for tests but are able to have tests within primary care, this may improve the perception of primary care as expert providers. Also, it could at some point be possible for patients

to do some tests by themselves at home, e.g. urine tests (see section 5.6).This may be able to reduce unnecessary visits to the GP as well as A&E.

b. Inform patients more about GPs' Special Interests. Use these to rationalise appointments so patients feel they are seen by an expert. If possible refer patients to other GPs who have a particular expertise.
c. Every effort should be made to involve patients in their care so that they do not feel more involved in their care at A&E than at their GP practice.

4. A minority of patients are unhappy with their relationship with their regular GP (See Findings 1.4.3). This could be caused by some poor clinical practice or poor communication. For some patients it may be better to change GP practice.

   a. Ensure all patients know how to change GP and are aware that this will have no consequences for their care. This information should be visible in GP waiting rooms and cascaded through community groups. This project found that a substantial minority (20%) did not know how to change GP (see Section 5.20).
   b. Ensure wherever possible that patients with language needs have easy access to an interpreter. Language line and face to face interpreting services already exist and should be utilised systematically.
   c. Reception staff should be trained in working with a diverse community and particularly in working with people whose first language is not English and/or people who suffer from anxiety or mental distress (see Section 5.22).

5. Further research should be carried out with patients who attend A&E repeatedly to find out why they do so and what would make them decrease the repeated use of A&E.
6. Improve referrals to community organisations and to community run health programmes (such as the community champions, health trainers, Wellwatch, Diabetes Mentoring Scheme, Expert Patient Programme, Diabetes Prevention Scheme, mental wellbeing programme and other health & wellbeing services, etc) as these may be able to support patients to stay well and to understand how to access NHS services appropriately.
7. Provide workshops for GPs and Practice staff on what local community organisations are providing that can support patients.

7.2. Recommendations for Changes in A&E and Urgent Care Centres

1. When patients visit A&E inappropriately their experience should be as similar as possible to attending a GP practice (see Findings 1.4.2 and Section 5.5 and 5.8). For example:

   a. Patients could be told that they cannot be seen at A&E and have an appointment booked for them with a GP where they can be seen with 4 hours.

b. Patients could be seen by a GP at A&E who would follow the same processes as a GP based in the community (same access to tests etc).
c. Ensure that when a patient goes to A&E the staff have access to the patient's records to ensure that no unnecessary tests are done or repeated to avoid giving patients the impression that an examination at A&E is more thorough.

7.3. Recommendations for Changes in Community Provision

1. Community organisations could be involved in delivering a community education programme that raises awareness within different BME communities about when to utilise which NHS services and what the different services provide. The community education programme should also engender a sense of responsibility with communities in relation to how and which services they access and the cost of utilising emergency and urgent care as opposed to GP and other services. Such a programme could be delivered alongside other community health education programmes such as ESOL for Health or the Expert Patient programme.
2. Make some provision for community health advocacy which could support patients who have unresolved issues with their primary care in order to ensure they are able to access appropriate primary care and do not attend A&E as a default.
3. Provide a structured health education programme targeting people who do not speak English that can support people to manage their long term conditions and teach them how to best manage their appointments with their GP, book double appointments if needed, and make complaints. This could be done in the Expert Patient model with sessions run in Arabic, Somali and Bengali, and in the ESOL for Health model to support people improve their English at the same time.

7.4. Recommendation for changes in the collection of Ethnicity data

The BME communities constitute 38.4% of the population in Westminster but 48.6% of the sum total of all A&E attendances. Individual groups of 'categorised' BME communities do not represent high A&E usage compared to the different white categories except for the category 'Any other ethnic group.' The 'Any other ethnic group' constitutes 11.1% of the local population and yet has 26% attending A&E (see Section 4).

1. NHS Trusts delivering A&E and urgent care services for the population of Westminster have a contractual obligation to collect ethnicity data. This needs to be done to a higher standard in order to identify who the 26% attending A&E are in order to target the community education programme towards these groups. To achieve this, it is likely that more ethnicity categories would have to be used that are not in line with the categories used by the ONS such as Arab and Somali. For example the African category realistically does not provide very useful data as

Africa is a very large continent with many different countries, ethnicities, cultures and languages. Effective targeting will only be possible if the data collected can identify more precisely the ethnicity of the patients (see Section 3.2 where participants were asked to describe their ethnicity).

8. Glossary

BME

Black and Minority Ethnic

Cared For

Person with illness, disability, mental ill-health or a substance misuse problem who is cared for by family or friends

Carer

The definition of a carer as defined by the Princess Royal Trust for Carers (PRTC) is:

“A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help due to illness, disability, mental ill-health or a substance misuse problem.”

Central London CCG

Central London Clinical Commissioning Group

Healthcare Professionals

In this study includes Hospital Doctors, GPs, Nurses, Midwives and Ancillary staff

CNWL

Central and North West London Trust

LTC

Long term conditions (including physical health and mental health). Though in this y it also includes Learning Disabilities.

9. Appendix 1: GP Practices in the NHS Central London CCG area

1. Cavendish Health Centre, 53 New Cavendish Street, W1G 9TQ
2. Covent Garden Medical Centre, 47 Shorts Gardens, WC2H 9AA
3. Crawford Street Surgery, 95-97 Crawford Street, W1H 2HJ
4. Crompton Medical Centre, 1 Crompton Street, W2 1ND
5. Dr Shakarchi's Practice, The Belgrave Medical Centre, 13 Pimlico Road, SW1W 8NA
6. Dr Victoria Muir's Practice, Belgrave Medical Centre13 Pimlico Road, SW1W 8NA
7. Fitzrovia Medical Centre, 31 Fitzroy Square, W1T 6EU
8. Great Chapel Street Medical Centre, 13 Great Chapel Street, W1F 8FL
9. Harley Street Surgery, 131 Harley Street, London, W1G 6BB
10. Imperial College Health Centre, 40 Princes Gardens, SW7 1LY
11. King's College Health Centre, 3rd Floor Macadam Building, Surrey Street, WC2R 2LS
12. Lanark Medical Centre (Ground Floor, Dr El Gazzar), 165 Lanark Road, W9 1NZ
13. Lanark Medical Centre (Third Floor, Dr Laila Abouzekry), 165 Lanark Road, W9 1NZ
14. Lisson Grove Health Centre, Gateforth Street, NW8 8EG
15. Little Venice Medical Centre, 2 Crompton Street, W2 1ND
16. North West London Medical Centre, 56 Maida Vale, W9 1PP
17. Maida Vale Medical Centre, 40 Biddulph Mansions Elgin Avenue, W9 1HT
18. Marylebone Health Centre, 17 Marylebone RoadLondonNW1 5LT
19. Millbank Medical Centre, Medical Centre Building, 20 Page Street, SW1P 4EN
20. Paddington Green Health Centre, 4 Princess Louise Close, W2 1LQ
21. Randolph Surgery, 235a Elgin Avenue, W9 1NH
22. Soho Square General Practice, First Floor, 1 Frith Street, London, W1D 3H
23. Soho Square Surgery, 30 Soho Square, W1D 3QS
24. St Johns Wood Medical Practice, 60 GROVE END ROAD, NW8 9NH
25. The Belgravia Surgery, 24-26 Eccleston Street, SW1W 9PY
26. The Connaught Square Practice, 41 Connaught SquareLondonW2 2HL
27. The Doctor Hickey Surgery, Cardinal Hume Centre (Homeless Participants Only) 3 Arneway Street, SW1P 2BG
28. The Marven Medical Practice, 46-50 Lupus Street, SW1V 3EB
29. The Mayfair Medical Centre, 3 - 5 Weighhouse Street, W1K 5LS
30. The Newton Medical Centre, 14-18 Newton Road, W2 5LT
31. The Wellington Health Centre, 16 Wellington Road, NW8 9SP
32. The Westbourne Green Surgery, Health At The Stowe, 260 Harrow Road, W2 5ES
33. The Woodfield Road Surgery, 7E Woodfield Road, W9 3XZ
34. Victoria Medical Centre, 29 Upper Tachbrook Street, SW1V 1SN
35. Westminster Health Centre, 15 Denbigh Street, SW1V 2HF
36. Westminster School Surgery, Westminster School