PROJECT: KENSINGTON, CHELSEA AND WESTMINSTER

Working closely with community organisations, an experienced team from Kensington, Chelsea and Westminster has improved access to primary care services for their local BME communities, and has researched and recommended an alternative way of commissioning these services.
The City of Westminster is one of London’s most ethnically and culturally diverse boroughs. Over 150 languages are spoken and it is estimated that 29% of the population belong to BME groups.

The Royal Borough of Kensington and Chelsea, the most densely populated borough in the UK, is also home to a wide range of BME communities.

There is evidence of significant variation in the health and wellbeing of the different communities in these boroughs, with residents from BME groups tending to suffer poorer health and having lower life expectancy than average.

The BME Health Forum is a collaborative partnership network between statutory, voluntary and community organisations in the two boroughs that aims to improve health and reduce inequalities for the local BME population. It does this by empowering communities to engage effectively with the health service.

The Forum was aware that people from BME groups in the area often didn’t know about the primary care services available to them, and that there were problems surrounding access to these services. In 2007 they commissioned a research project on access to GP services for BME groups, which highlighted significant levels of dissatisfaction. The main issues were around communication, caused by language and cultural barriers; access and use of interpreting services; relationships with GPs and practice staff; and the process of registering with a GP and making appointments.

To follow up on the recommendations in the report, the Forum ran a Good Practices for Access and Wellbeing initiative, which was the focus for its shared leadership project and ran from April 2009 to March 2010.

**PROJECT DETAILS**

**Project team:**
BME Health Forum, including:
- NHS Westminster
- NHS Kensington and Chelsea
- six community organisations

**BME target group:**
BME communities in Kensington, Chelsea and Westminster

**Aim:**
To improve access to primary care services for BME communities in the area
In early 2009, the Forum invited tenders from local community organisations to be part of the Good Practices for Access and Wellbeing project. They recruited six community organisations and funded each one to implement a series of initiatives aimed at improving access to primary care services for BME communities. The organisations did this through working with patients and primary care providers to develop services and improve relationships, while also increasing the community’s knowledge of how to access and use those services.

The six organisations involved were:
– Al-Hasaniya Moroccan Women’s Centre
– Chinese National Healthy Living Centre
– Kongolese Centre for Information and Advice
– Midaye Somali Development Network
– Queens Park Bangladeshi Association
– WSPM Agape Community Project.

Each organisation employed an access facilitator, whose purpose was to find out what issues their community have around primary care access; provide feedback to local healthcare providers; raise issues of behalf of the community; and educate the community on how to make effective use of health services. They also provided advocacy support to patients to help them make complaints or raise challenges, and to help overcome cultural or language barriers.

The six organisations co-authored a guide for patients on interpreting services and a guide to NHS services, both of which were translated into community languages. The access facilitators each developed support and referral systems for patients; worked with community members on using clinical consultation more effectively; and conducted focus groups and training sessions to promote better relationships with GPs and practice staff.

Through their work with community organisations and primary care services, the Forum identified examples of best practice that could potentially be mainstreamed across the NHS. In order to investigate how other countries deal with health inequalities, Forum members visited Toronto, Canada, to find out about a different system of delivering healthcare to a diverse population, and to identify learning that could be applicable in the UK. This learning led to the Forum developing a series of recommendations for a significant change to the way that primary care services are commissioned (see ‘Learning from Toronto’ on page 14).
Community development

The team worked closely with the six community organisations. Some of these relationships were new and some were existing. The project also helped improve capacity within the six organisations.

‘The project should also be about helping organisations to evolve their capacity around health services. The benefits of this are two-way.’

Brian Colman, Head of Equality and Diversity, NHS Westminster

Community organisations are in the strongest position to educate and share information with their communities. The project team utilised the strong links that the community groups have with BME groups to uncover what the barriers to access were, and to seek out ways in which improvements could be made.

Engagement with these community organisations was highly effective and the BME Health Forum provided an existing platform from which to influence providers of care.

A targeted approach

Clinical engagement was a challenge for many of the organisations involved in the project, and for the project team. In particular, the project team found there were specific barriers to engaging GPs in the project.

‘The focus for GPs is, by the very nature of their work, on individuals, whereas we are talking about communities as a whole. There was also difficulty with defining what we meant by ‘access’. Often GPs see this as number of patients and opening hours, whereas it isn’t just about that, it is about the quality of that access and patients receiving care that is tailored to their needs. Getting that message across was difficult.’
The team learned that they had to be more targeted in their approach to engaging with both the service providers and communities.

‘It was vital to take account of where people are and what their agenda is. We became better at that and developed targeted recommendations for each problem. Our recommendations became more focused.’

The team found that once they had practical materials to help them, for example the guides to interpreting, GPs were more likely to be engaged with the project.

‘We could then go back and say we have these practical things; we can help you in your day-to-day work with patients.’

LEARNING FROM TORONTO

Toronto was chosen as a particularly relevant city to the shared leadership project as the Canadian health system shares many similarities with the NHS, and Toronto has a high BME population and an informed health system in terms of BME issues.

Toronto has a network of community health centres (CHCs), which are voluntary organisations that offer local people a number of services, including health services. They are aimed at communities that face barriers to accessing primary care. CHCs are multi-disciplinary; supporting patients not only by providing clinical services, but also dealing with the social, environmental and economic determinants of health.

Evidence suggests that CHCs are cost effective in improving access to healthcare in Canada, as they reduce hospital admissions, reduce inappropriate referrals and make effective use of non-physician clinicians such as nurses.

The CHC model is over 20 years old and the number of CHCs is expanding. The success of CHCs indicates that rather than focusing exclusively on mainstream GP practices as the sole route for access, it may be more cost effective if the NHS were to invest in separate structures that specifically tackle access for vulnerable populations.

The BME Health Forum has made a series of recommendations for changing the way primary care is commissioned in light of their experiences during the Toronto visit.
The project has resulted in an increased awareness of primary care services among BME communities in the area, increased use of formal interpreters and greater awareness of how to access an interpreter. The access facilitators improved relationships between the communities and the service providers, and their one-to-one work with patients proved highly successful.

‘Two of the community organisations have managed to source funding to allow the access facilitators to continue with their work.’

The project also raised the profile of the BME Health Forum and it is now being recognised as a model of good practice. The findings of the project, including the CHC model seen in Toronto, have been fed into a series of recommendations for changing the way primary care is commissioned in the area.

The leadership development work that was part of the project has also had a significant impact. The processes and structures put in place have helped to create a stronger, more effective team.

‘The team bonding element has been very important, and will have a lasting effect. It has changed the culture of the team, and that will remain. It has made us work better as a team and everyone is willing to contribute to its success.’

Nafsika Thalassis, Project Coordinator, BME Health Forum
TIPS AND ADVICE

Take calculated risks

The Forum hadn’t worked with some of the community organisations previously, and knew that providing funding when they didn’t know how successful they could be was a risk.

‘We knew it was risky to use some of the less-developed organisations, but we also knew we had to take risks in order to have an impact. Some of the organisations did better than others, but that was a risk we had to take.’

Have a long-term view

Influencing changes to commissioning takes time, which can be challenging when trying to engage people in the project.

‘The outcomes for projects with BME communities tend to be long-term. The idea of investing now for the future can be problematic, particularly in the NHS where decisions are often driven by short-term goals, and are, understandable, very treatment-focused.’

Stick to what you know will work

The Forum had experience of working with the community and so knew that it was the best way to go about this project.

‘The project confirmed my belief that it is the right way to go about things, in terms of improving quality of experience, that involving communities themselves is the right approach to take.’

Look behind the figures:

Data on GP consultations can sometimes show that BME groups have high rates of consultations. However, this can hide the real picture.

‘More consultations can also be a measure of poor access as repeat consultations may mean that the patient has had to go a few times to get heard. It is about having fewer sessions that are of better quality.’