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Enfield Racial Equality Council (EREC) is an umbrella organisation in Enfield concerned with racial discrimination and equality of opportunity in every aspect of your life. We are a not-for-profit organisation and receive public funds to carry out the work that we do. We are a membership organisation and our members are from diverse backgrounds with a commitment to furthering race equality in Enfield. EREC receives core funding from the London Borough of Enfield. We also received funding from the Big Lottery for the Improving Health Project.

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Introduction

The project aims at assessing levels of health inequalities and discrimination in accessing healthcare in the London Borough of Enfield. In particular, it investigates the extent to which local providers of healthcare and health advice are able to cater for minority and vulnerable groups and the extent to which new bodies and structures implemented as part of the NHS reform are engaging with equality legislation and are able to offer mechanisms to implement it.

The project comprises of the following activities:

(i) **Desk research** to gather data on levels of health inequalities and barriers to healthcare in Enfield (based on existing reports, data and local intelligence) and on the changing structure of healthcare provision in the Borough;

(ii) **Mapping** of existing health providers, focusing mainly on GP practices and also includes health advocacy groups and community organizations in Enfield in order to assess what services they offer and how they engage with equality issues and legislation;

(iii) **Qualitative data collection** involving interviews with at least 3 different patient groups (focusing on women of reproductive age, elderly people and young people with learning disabilities) and a focus group with local health stakeholders.

The barriers that migrants and BME groups experience when trying to access health services have been one of the foci of the comparative European Fundamental Rights Agency project *Inequalities and Multiple Discrimination in Access to and Quality of Healthcare* coordinated by the SPRC (Social Policy Research Centre) at Middlesex University. As part of creating a local impact for this major international project, the SPRC commissioned a follow up impact project to EREC (Enfield Racial Equality Council). EREC conducted the research under SPRC’s supervision, methodological guidance and advice.
Background of Research in Health Inequalities in the UK

Research on health inequalities in the UK goes back to the Black Report in 1980 which showed that there was an unequal distribution of ill-health and mortality among the UK population and that these inequalities in health have been widening since the formation of the National Health Service in 1948. Moreover, the Black Report did not attribute these inequalities primarily to the shortcomings of the NHS. Rather, the Report concluded that a multiple of other social inequalities (e.g. education, income, employment, diet and housing) played a determining role. At the time, however, there was a lack of political will to take the Report’s findings and recommendations forward. In February 2010, an influential report by the Marmot Review Team, entitled, ‘Fair Society, Healthy Lives’, was published. This year-long independent review on health inequalities in England reiterated that health inequalities arise from the complex interaction of a multitude of social factors, all of which are greatly affected by a person’s economic and social status. However, according to the Triennial Review conducted by the Equality and Human Rights Commission (Allmark et al., 2010), there has been a welcome policy and research focus on inequalities in health in the UK in the last 10-15 years. This has suffered from a tendency to focus on individual life-style factors and away from structural socioeconomic and socio-political inequality and a lack of attention to the needs of particular equality strand groups. The EHRC review goes on to say that there have been no explicit targets that address inequalities between equality strand groups, for example relating to health outcomes for minority ethnic groups, and this has meant that other priorities have often taken precedence. There are, nonetheless, examples of good practice in terms of policy and strategy documents that deal in detail with the needs of particular groups in relation to particular health outcomes but the issues are not mainstreamed, so that policy attention remains patchy. This report also highlights that there is evidence across the equality strands that the failure of NHS services to recognise and meet diverse needs undermines health outcomes and contributes to poor satisfaction with services. These healthcare experiences in many ways reflect the discrimination and exclusion that occurs in the wider society.

Although there is growing academic, legal and policy literature on multiple and intersectional discrimination, much of it has highlighted issues concerning employment (see GendeRace, 2010). Therefore, the Fundamental Rights Agency project (2011) on Inequalities and Multiple Discrimination in Access to and Quality of Healthcare is the first to address intersectional discrimination in health at a European level. However, under the current British legal system, multiple grounds of discrimination have to be treated separately. The original drafting of the Equality Act 2010 did include provision for what is called combined discrimination or dual characteristics, but this was taken out by the Coalition Government.

The term ‘discrimination’ is commonly used and understood in relation to employment unlike in health where, even when it occurs, it is rarely mentioned. Rather, it is the quality of the treatment, which is raised in relation to complaints. In addition, institutional mechanisms for dealing with complaints have undergone substantial change. The Equality and Human Rights Commission was established as a single body covering all equality strands in 2007 while the Health Ombudsman and the Care Quality Commission began their work in 2009. There do not appear to be any discrimination cases relating to access to health, but there are cases that have been dealt with otherwise but which could have been framed in terms of discrimination and/or multiple discrimination. The Equality Act has now extended discrimination to the provision of services, including health and the Public Sector Equality Duty (PSED), which previously only extended to sex, race and disability, now extends to age.
The British Health System

The British health system has been the subject of considerable change since its inception in the 1940s, but many of its underlying principles, most notably, the fact of being free at the point of use, are arguably still intact. It is also important to note that constitutional changes since 1998 have devolved differing degrees of autonomy and responsibility to governments in Scotland, Wales and Northern Ireland. This accounts for variations in health policy and provision in these devolved authorities. The National Health Service (NHS) was established in 1948 as a universal health service, funded by general taxes and National Insurance contributions. The aim was to provide healthcare for all free at point of access, regardless of ability to pay. However from the early 1950s, fees for prescriptions, spectacles and dentures were introduced around concerns of escalating costs. From 1948 onwards, the NHS expanded as expectations rather than needs increased. The expansion (and ultimately cost) was expedited by demand as well as increasing medical knowledge, technology, pharmacology. Although concern about the burgeoning cost of health services was evident from the early years of the NHS, reform only really began from 1979. Dramatic reforms by the New Right government in the 1980s and 1990s aimed to preserve the basic principles of NHS while improving delivery, quality and expenditure through better management, increased efficiency, internal markets and structural reorganisation. Decisions about treatments, medicines, effectiveness of interventions and health prevention were devolved to the independent National Institute for Health and Care Excellence (NICE) in 1999. The Commission for Health improvement became the Healthcare Commission in 2001, taking responsibility for assessing the standards of NHS trusts, private and voluntary sector providers.

From the late 1990s, increased investment was coupled with greater top-down control from the Department of Health. This included targets for service improvement particularly in relation to National Service Frameworks (NSF) for a range of conditions, reductions in waiting lists, waiting times, and “joined-up” social and healthcare services. GPs in the form of Primary Care Trusts (PCTs) were allocated budgets to commission care from hospital and other providers. NHS Direct, a 24-hour telephone consultation service and walk-in centres staffed by nurses were developed to improve access to health services. Since 1 April 2013, PCTs have been abolished and many of their functions have been taken on by clinical commissioning groups (CCGs)—these new organisations are responsible for commissioning most health and social care services for local populations, such as, planned hospital care, urgent and emergency care, rehabilitative care, mental health and learning disability services and most community health services. CCGs can commission any service provider, such as NHS hospitals, private sector providers, charities or social enterprises, however, quality assurance of the services they commission is important, drawing on NICE guidelines and Care Quality Commission's (CQC) data on service providers.

Separation of health and social care

Perhaps one of the most unique aspects of the British health system is the separation of health and social care. Although this has been renegotiated in recent years, the separation has impacted on what is defined as health care, who provides it, who funds it and who receives it. Social care was differentiated from health care as early as the 1930s but cemented by the various acts of parliament, giving local authorities responsibility for social (personal) care, residential homes, day
care and home care which would be charged for according to means, while health care remained free at point of access.

The 1960s saw the first significant steps towards community care, largely driven by concerns about the quality of provision and the “institutionalisation” of children, older people and those with mental illness or disabilities. A significant proportion of the health and social security budget was spent on private sector residential care for older people and was predicted to rise. However, the NHS and Community Care Act 1990, shifted responsibility for residential and social care to local authorities, thus reducing NHS costs. Local authority social services departments were permitted to charge means-tested individuals for personal services, although, long-term care continued to be free under the NHS until redefined as social care (with the exception of nursing care) in 2000. Since the late 1990s, following pressure from the disability lobby, people in need of care and support were able to be funded directly to organise and manage their own care. Although only provided to people under 60s, “Personalised Budgets” are expanding for all groups in need of care as part of the social care agenda.

While certain categories of the population such as children and people over 60 years of age have continued to have free prescriptions, the cost to those who have to pay has increased significantly. Eligibility for free dental care, eye testing and spectacles has changed with increasing numbers having to pay all or some of the cost. NICE scrutinises the evidence-based effectiveness of drugs, surgical procedures and, more recently, has offered guidelines for the investigation and treatment of many common conditions, which place demands on healthcare. Therefore, certain investigations, operations, drugs and therapies are either not provided or offered very selectively because evidence shows they are not cost-effective. Waiting lists for specialist consultation and treatment and waiting times in casualty departments have reduced dramatically following the introduction of penalties for failure to meet targets. However, it is argued that these targets interfered with clinical decisions and may have impacted most on vulnerable groups.

Institutional Structure – Shifting Sands

The structure of health and social care delivery is undergoing a rapid and massive change. Changes to the health and social care system and a number of reports and commissions over the last three decades have paved the way for recent reforms in the long-term vision for the NHS. Reforms are enshrined in the Health and Social Care Act 2012. Although some adaptations are inevitable, the broad intentions are unchanged. The espoused intentions are to put patients at the heart of the NHS, improve outcomes and empower local organisations and professionals. As the name of the Act implies, the amalgamation of health and social care is central. The Act stipulates the following:

- Establish an independent NHS Board to allocate resources and provide commissioning guidance
- Increase GPs' powers to commission services on behalf of their patients
- Strengthen the role of the Care Quality Commission
- Develop Monitor, the body that currently regulates NHS foundation trusts, into an economic regulator to oversee aspects of access and competition in the NHS
- Cut the number of health bodies to help meet the Government's commitment to cut NHS administration costs by a third, including abolishing Primary Care Trusts and Strategic Health Authorities.

With particular reference to health inequalities, the Act establishes the legal architecture of a new public health service—Public Health England—combining the existing Health Protection Agency and the National Treatment Agency. Funding for public health will be ring-fenced (for the first time) with some resources protected for population-wide issues and some protected to local inequalities. It is envisaged that a new premium will reward progress in addressing inequalities.

Local councils are now responsible for improving health locally, particularly for those with the worst health. Directors of Public Health have to work with the NHS, local communities, charities and businesses, and GPs now have a greater role in prevention. The Act also establishes the legal framework for the NHS where patients and carers are at the centre of decision-making. In addition, Local Involvement Networks (LINks) and Healthwatch aim to give the public and patients a voice within the independent Care Quality Commission (CQC).

The vision for the NHS is that improved outcomes will be achieved by a shift from centrally driven process targets to transparent local outcomes within a NHS Outcomes Framework, which holds the NHS Commissioning Board to account. The government replaced top-down control with clinically-led commissioning, thus devolving commissioning to consortia of GPs who will purchase services for local people. GP consortia will be accountable to the NHS Commissioning Board and will work within a Commissioning Outcomes Framework, which will reward patient outcomes and clinical performance. It is believed that better health and well-being will be achieved through greater collaboration between NHS and local authorities, and will function through Health and Well-being boards to assess needs, develop appropriate strategies and scrutinise performance of providers of NHS funded care. Moreover, the recent healthcare reforms in England are likely to mean a larger role for the private sector in the NHS, mainly in community health services, with its claims to greater efficiency and innovation. Even so, while independent healthcare providers might offer new models of care for patients, future NHS provision is still likely to remain very much in the public sector.
Primary Care

The primary medical care contracting arrangements enable the NHS to provide a wider range of General Practitioner (GP) services closer to where patients live and improve the quality of care provided. They are usually the first point of contact for a patient seeking treatment or advice about their health and around 90% of people’s contact with the NHS is with these services.

GP contracts are funded from Clinical Commissioning Groups’ (CCGs) budgets. All GP practices in England belong to a CCG and these groups also comprise other healthcare professionals, such as nurses. CCGs commission the majority of healthcare services, including most community health services, planned hospital care, urgent and emergency care, mental health and learning disability services and rehabilitative care. Moreover, GP practices act as both the gateway to, and coordinator of, patient access throughout their care journey (pathway). GP practices have a close relationship with wider community services—social care and health services. Core community services such as community nurses and health visitors are often co-located within defined localities based around primary care providers, such as GP practices. More specialist community services, such as podiatry, speech and language therapy, school nursing and health promotion, are similarly based around defined local communities and have a close interface with primary care providers. Dental, ophthalmic and pharmacy services are also part of primary care in England.

General practitioners (GP) have always operated as self-employed contractors, paid on a per capita basis for primary care services, with additional payments for preventive medicine, screening and incentives or bonuses for working in deprived areas. GPs also act as gatekeepers to the NHS, having to refer patients for specialist consultations, investigations surgery or other treatments.

Private healthcare/private partnerships

A small private healthcare market has existed alongside the NHS, mostly staffed by NHS doctors operating outside their NHS contracts. The cost of private provision is generally met by private health insurance through specialist and general insurers. However, as insurers are under pressure to keep costs low, private health care providers only provide a limited range of hospital services, mostly non-acute.

The number of privately insured patients has increased since the 1970s. The 1980s involved a massive expansion of private hospital care, and the contracting out of a variety of non-core hospital services, although the overall proportion of spending on private health remained proportionately low. However, this period saw a significant expansion of private sector residential and long-term care for older people and those with mental illness and disability. The shift to community care also led to an increase in provision by the private and voluntary sector funded by local authorities responsible for enabling community care.

Although health services remained within the public sectors, greater collaboration between public and private sectors has become more important, particularly in the drive to meet waiting list targets. Apart from contracting out support services, the NHS has outsourced certain diagnostic services, elective surgery and other ancillary functions to the private sector. It has also engaged in public private partnerships, such as the controversial Private Finance Initiative (PFI), by using private finance to build and equip hospitals then leasing them back to the public sectors to reduce public expenditure costs. There is considerable concern about the effectiveness of these initiatives.
As discussed earlier, the NHS is undergoing a radical re-structuring under the current UK Coalition Government. We will look at changes in national structures before highlighting the structural changes at local level, using the London Borough of Enfield as a case study.

**National Structures**

In terms of changes, now as before the Department of Health (DH) supports the Secretary of State for Health in setting national policy and legislation. The Care Quality Commission (CQC) is the independent regulator of all health and social care services in England and its role is to make sure that care provided by national NHS bodies meets national standards of quality and safety. Monitor is the sector regulator for health services in England. Monitor promotes the provision of healthcare services which are effective, efficient and economically sustainable and maintains or improves the quality of services. It assesses NHS trusts for foundation status. Healthwatch England (HWE) is the independent consumer champion at the heart of social care in England, and works with a network of 152 local offices of Health Watch, to ensure that the voices of consumers and those who use services reach the ears of the decision makers.

Public Health England (PHE) is the new name for what was previously known as the Health Protection Agency. PHE’s role is to improve the nation’s health and well-being and to reduce health inequalities. It will provide national leadership for locally led public health services and expert services to respond to health protection emergencies, working alongside local government, the NHS and other key partners. PHE is an executive agency of the Department of Health.

Health Education England (HEE) is the new national leadership organisation for the education, training and development of the healthcare workforce. It supports improvements in care for patients by ensuring that the right numbers of staff with right skills are available wherever they are needed. It operates through 13 local education and training boards across England, each covering a particular area.

NHS England (formerly NHS Commissioning Board) is an independent body managing the NHS budget and commissioning services. It oversees the work of the Clinical Commissioning Groups (CCGs) and allocates resources and commissions services, such as primary care. It is accountable to the Health Secretary. Enfield comes under NHS North Central London region. England has 211 CCGs that are independent statutory organisations, accountable to their communities and their board. As mentioned earlier, clinical commissioning groups are new statutory organisations created on 1st April 2013 by the Health and Social Care Act 2012 to replace Primary Care Trusts. Their role is to commission and monitor a wide range of health services for patients.

Essentially, the new NHS reforms under the Health and Social Care Act 2012 seek to reduce health inequalities through the newly established body Public Health England which aims to collaboratively tackle the social determinants of health and enable and support lay people and communities in improving their own health. Moreover, this legislation, for the first time, explicitly bestows upon the Secretary of State, NHS England and CCGs, a duty to consider the need to reduce inequalities in health access and benefits from healthcare services. At the same time, CCGs’ responsibilities can aid in reducing health inequalities through promoting better integration of health services to ensure
service quality and improved health outcomes, and in their duty to engage their patients, carers and the public in the planning of commissioning arrangements and decisions that affect them.

Local Structures (Enfield)

Healthwatch Enfield is the new independent local consumer-led body for health and social care in the Borough. It replaces the Local Involvement Network (LINk). Local residents were able to put themselves forward for a reference group and also for the steering group. It is now developing its own terms of reference and identity. Its aim is to be the voice of local people to influence provision and decisions of policy makers in health. At the time of writing this research, the Chair of Healthwatch Enfield is Deborah Fowler and Lorna Reith is the Chief Executive who joined Healthwatch Enfield in September 2013.

Enfield Council has been given responsibility for protecting and improving the health of their residents and has a ring-fenced grant for this purpose. At the time of writing Dr Shahed Ahmad is the Joint Director of Public Health for NHS Enfield and Enfield Council. He and a specialist team are employed to carry out this role, which also identifies needs, gaps and priorities. They are required to produce a Joint Strategic Needs Assessment (JSNA), which is currently being redesigned. The Borough Council’s lead is Councillor Christine Hamilton, Cabinet Member for Community Wellbeing and Public Health.

Enfield Education and Training Boards (EETBs) are responsible for workforce planning, education and training at a local level and they are accountable to Health Education England, which is responsible for the development of every member of NHS staff.

There is a CCG in each London Borough and, with regards to NHS Enfield CCG, every GP practice in Enfield is a member of the Enfield CCG and works in partnership with all healthcare professionals in Enfield in order to provide the necessary care and support for their patients’ needs. NHS Enfield CCG works with the local community and health partners, for example hospitals and social services, doctors, dentists, opticians and pharmacists, to deliver health services that are responsive to the needs of local people. Enfield CCG is responsible for improving the health of Enfield people, commissioning hospital services, and developing primary care and community services.

Enfield has three main acute hospital partners, a community trust called Enfield Community Trust, 54 GP Practices and several walk-in centres, ambulance services, dental practices, optometrists and pharmacies. The Governing Body of Enfield CCG is made up of elected GPs who represent their localities and is chaired by a GP and supported by NHS managers, other health professionals and patient and partner representatives. Each locality elects two representatives to the Governing Body.

Enfield CCG’s Governing Body has five committees, which include Audit, Remuneration and Nomination, Quality & Safety, Financial Recovery, Quality, Innovation, Productivity & Prevention (QIPP) and Patient & Public Engagement (PPE). Enfield CCG is currently recruiting four volunteer representatives that can help develop Patient Participation Groups (PPGs) across Enfield and also represent their views at the CCG’s Quality and Safety and Patient and Public Engagement Committees. These will be interim roles for a fixed-term of one year, and one PPG representative will also be asked to sit on the CCG’s Governing Body.
**Patient Participation Group (PPG)** is encouraged by CCGs and any patient can apply to join their GP Practices Patient Participation Group and have a say in the priorities and service delivery of the practice. The practices have agreed a constitution, which sets out governance arrangements and describes how the practices will work together.

**Enfield Health and Well-being Board** are forums where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and Wellbeing Boards are responsible for leading on the Joint Strategic Needs Assessment (JSNA) and the new Joint Health and Wellbeing Strategy, an overarching commissioning strategy for each area, in conjunction with the public health team.

Essentially, Enfield Council’s strategic aim of ‘Fairness for All’ means that it seeks to serve the whole Borough fairly and tackle inequalities. As a result, Enfield Health and Well-being Board are committed to reducing inequalities in health and well-being that exist across the Borough, meaning that particular groups in the local community will also be targeted for improvements in health and well-being. Thus, central to the delivery of the **Joint Health and Wellbeing Strategy (JHWS)** in Enfield is addressing health inequalities in the Borough and making a difference by reducing the gap in life expectancy and improving public services. Of importance, priority is given to the monitoring of the JHWS in Enfield whereby Equality Impact Assessments (EQIAs) will be conducted to respond to changes in local services/commissioning decisions.
Implementing Equality Legislation in Enfield

It is the role of CCGs and NHS England to implement requirements of the Equality Act 2010 (Doran, 2012), which requires public authorities to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

The Act does not specify how the above should be done—it is up to each organisation to decide on the most suitable method. Due to the changes in NHS structures coming into effect very recently, it is hard to discern who is responsible for equalities in each of organisations.

According to the *Equality and Diversity Report* (2012, p2), each NHS Hospital Trust has to provide an Equality and Diversity Report on performance every year, using the NHS-wide Equality Delivery System (EDS) as its framework for the performance management of its compliance with the Public Sector Equality Duty under the Equality Act 2010. The annual *Equality and Diversity Report for 2012* sets out the evidence for the Trust’s performance in delivering on its commitment to equal opportunities, celebrating diversity and tailoring care to the individual needs of its entire service users. The EDS is a developmental performance framework, which asks those with an interest in the work of the Trust—service users, carers, staff and their representatives—to grade the work of the organisation based on the evidence it provides. Much of that evidence is listed in this report. The National Framework for NHS continuing Healthcare and NHS funded Nursing Care was revised in November 2012 and will continue under the new NHS framework and structures. Part of this framework requires assessment of individuals’ eligibility and care packages designed to meet their individual needs. The eligibility assessment process incorporates an equality monitoring form, to be completed by the individuals being assessed.

According to the report *Our Commissioning Prospectus 2013-2014* (2013, p 4), the CCG’s role is to commission and monitor a wide range of health services for patients, including emergency care, community care, planned hospital care, mental health and learning disability service. As mentioned above, there is a CCG in each London Borough and every GP practice in Enfield is a member of the local CCG and works in partnership with all healthcare professionals in Enfield to provide the necessary care and support for their patients’ needs. The NHS England and CCGs will use this information to identify whether individuals from the different groups (in terms of disability, ethnicity, etc.) are accessing NHS services equitably. The Department of Health will work with the NHS England and the Information Centre for Health and Social Care to ensure that national datasets continue to be collected and published. This assists CCGs in understanding the demand for NHS Community Health Care in their localities. The NHS England and CCGs are responsible for this area of work and should take steps to address any issues of concern or gaps identified from particular groups or communities. In Enfield, the Public Health Team and CCG will be conducting impact assessments as part of their consultation process on the Joint Health and Wellbeing
Strategy, which has recently been developed by the Health & Well-being Board\(^1\). The Public Health Team is also interested in gathering needs-based data by equality strands. They need qualitative and quantitative information to inform the JSNA.

**General Practitioner database in Enfield**

As part of the mapping activity for this research project we gathered a small database with GP practices and other agencies/health organizations and charities in Enfield. Information to be collected includes location and contact details; size (both in terms of staff/doctors and clients); structure; any specific activities or service addressing the needs of minority groups; any equality policy in place. From the database of GP practices in Enfield, it emerges that there is little evidence or no knowledge about any kind of specific services offered to BMEs other than language. When asked about specific provision for BME people, some practice managers were immediately defensive about the notion of providing additional services and responded along the lines, “we treat all patients in the same way.”

A telephone questionnaire on “Accessing Healthcare in Enfield for the BME communities” was conducted with Enfield-based GP practices. The questionnaire consisted of six main questions (see below) directed to the Practice Manager to answer on behalf of the practice; these included:

1) How many GPs does the practice have?
2) Please list the job titles and number of other members of staff employed by the practice?
3) Please list any services/activities that are aimed specifically at addressing the needs of Black and Minority Ethnic communities.
4) Please specify if an Equality & Diversity Policy (or other) is in place?
5) If you require training to formulate or implement this, please describe your needs.
6) Is there anything specific about your practice or any special features, such as different languages spoken, Language Line used or other?

In total, 55 practices were identified and a database was set up detailing their contact information and recording their responses. Out of the 55 that were contacted by telephone, it was only possible to speak to 36 Practice Managers and obtain their response to the questionnaire. Most of these were very happy to help, but had limited time due to their heavy workload. Several calls were made to practices where the telephone remained unanswered, was constantly engaged or where the call was held in a queue for lengthy periods. The remaining Practice Managers were either unavailable, on leave, or requested the survey in writing.

Consequently, for those who had not responded by the 25\(^{th}\) July 2013, the questionnaire was sent by first class post to the remaining 19 Practice Managers together with a covering letter and first class stamped addressed envelope for their response. These were followed up by several further attempts to contact them by telephone and some by email (where email addresses had been obtained).

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\(^1\) www.enfield.gov.uk/jhws
Services aimed at addressing the needs of the BME community

With regard to the question asked about whether the practice aimed any specific services at BME communities: all practices answered ‘no’ with exception of one. The following statements/comments were also made in relation to this question:

“We do not discriminate”
“Our services are inclusive”
“A blanket service is provided”
“Patients are dealt with according to symptoms presented, whatever their ethnicity”
“Everyone is treated the same”
“If we are unable to treat a condition here, then patients are referred elsewhere”

Equality and Diversity Policy

The vast majority of practices have an Equality Policy in place and most said they did not require any training at present, but were happy to be contacted with details of the training being offered. When probed, it appeared that some of the practices discussed their policies at staff meetings; however, others stated that the policies were just included in the staff handbook provided to new staff. It emerged that although some practices kept a folder of their policies, staff may not have had any specific training on them. Three practices specified that they did not have an Equality Policy and required training.

Tackling diversity

The majority of practices used Language Line or interpreters as needed. Some patients were asked to bring along a family member or friend to translate; however, this was not always appropriate, depending on the nature of the need or privacy request. Some practices said that language was not really an issue and one or two stated, “We get by.” It appeared that in some areas where a particular minority community was prevalent, practices were attended where a GP speaking the same language was based.

Size of GP practices

With regard to patient list, we were advised by the Head of Primary Care Commissioning at NHS Enfield CCG that this information was private and confidential as it related to funding received by the practice. Hence, this question was not included in the questionnaire.

Accessibility of buildings

From discussions held with a Clinical Commissioning Group representative, it emerged that there is a big issue concerning the structure of some buildings which house GP practices because they are in need of modernization. The kind of services that can be provided may therefore be restricted, resulting in GPs being unable to deliver all the services they would wish to. Often these buildings are inaccessible or not accessible enough and hence may not always be compliant. Again, this
question was left out of the questionnaire as we felt it too difficult and time consuming to be answered over the telephone.

**Contacting the practices**

Practice email addresses are not advertised, nor do they appear on any public NHS contact lists, with one or two exceptions. However, we have identified colleagues in the health field that are privy to this information and are willing to disseminate information on our behalf to the Practice Managers, if required. This may prove more helpful as they would be more inclined to act upon these or respond if coming from them rather than us, particularly as Practice Managers are extremely busy and, therefore, likely to prioritise urgent medical health issues.

**Other observations**

We observed that there was a tick box attitude to E & D and most said they had a policy, however most did not feel they needed that policy for anything else other than legal requirements. Language Line was not mentioned as much as receiving translation services through the NHS. There was a heavy dependence on staff being able to speak the language of the local community and that was seen as enough. Moreover, there was little awareness about the need for any targeted medical campaigns towards BME groups, e.g. high levels of diabetes among the Asian community, and HIV awareness among the African community etc. From a preliminary search, it is evident that there is a gap in knowledge about the specific needs of local BME communities, what Equality and Diversity (E & D) is about and how is it relevant to surgeries. There is also little guidance and awareness with regards to what GP surgeries can do to improve E & D work and awareness about their communities. Despite all the research which is being published in that field, there is little awareness of medical needs which are specific to BME communities.
Accessing Healthcare in Enfield: An Overview

Enfield Racial Equality Council’s Improving Health Project (funded by the Big Lottery Fund) undertook a mapping exercise in summer 2007 with key local stakeholders and community groups. This exercise identified the key health conditions felt to be prevalent within the BME communities as heart disease, high cholesterol, diabetes, stroke and mental illness. BME groups also felt arthritis, eye conditions, asthma, eczema, multiple sclerosis, and osteoporosis as affecting their communities. The project identified language barriers as a major issue in accessing appropriate healthcare. This was also reiterated in our focus group discussion on 4th July 2013, on barriers to accessing healthcare by elders. Mr Tim Fenn from CCG’s South East locality at the time of writing, indicated that “it will be a challenge for GPs to meet and engage with the public and is important to ensure care is of a good quality throughout the Borough and all voices are heard, including those where English may not be a first language and where interpreters may be required.”

A recent workshop organised by the London Borough of Enfield to discuss inequalities in healthcare in Upper Edmonton indicated that people from Asian and Black Ethnic Groups are more likely to have diabetes and tend to develop the condition at younger ages (O’Neill, 2013, p.20). Enfield’s population is estimated from the Census 2011 data to be 312,500. 59.5% of Enfield residents are from Black and Minority Ethnic (BME) communities. At least 35% of Enfield’s residents were born outside the UK. The largest minority ethnic group is White Other, 18.2%, which includes communities from Turkey, Greece, Cyprus and Eastern Europe. All these figures are above London averages. The 2011 School Census records 154 languages or dialects being spoken by pupils who live in Enfield. The proportion of all such pupils whose first language was known, or believed not to be English, was 44%. The percentage of people over the age of 65 in Enfield is 12.7% and 28% are over the age of 50. These figures are predicted to increase over the next 25 years. At the younger end of the scale, 26.3% of people are under the age of 19 years. The annual average number of births in Enfield is around 4,800. At least 15.4% of people in the Borough have a long-term illness, health problem or disability that limits their daily activities or the work they could do. The number of older people with a diagnosis of dementia is estimated to be between 2,500 and 3,300 with a higher prevalence among women, and this number is predicted to rise by 10% over the next five years.

According to the report “Fairness for All” (2012, p.7-10), issues that adversely affect BME communities in Enfield include:

**Teenage pregnancy** is not evenly distributed either geographically or by ethnicity. 70% of conceptions take place to residents of four postcodes: EN1, EN3, N9 and N18. 29% of births are to Black African/Black Caribbean or White/Black Caribbean mothers (longer term result affects healthcare and poverty).

**Infant Mortality Rate** – Enfield has the third highest infant mortality rate in London.

**Obesity** – Enfield has the third highest rate of obese people in London (27% Enfield, 18% London) and the rate is higher than the national average. Obesity levels among Enfield’s young people are a particular concern—they are significantly above the England average with 25.1% of Enfield’s young people in year 6, and 14.6% in reception year being overweight.
Economic disadvantage – 64.6% of the working age population were in employment compared to 61.8% of ethnic minorities, and 26.2% of 16-64 year olds were economically inactive, compared to 29.1% of ethnic minority 16-64 year olds.

35.1% of children with a Somali background and 46.4% of children from a Turkish speaking background achieved 5 or more A* C grades at GCSE level, in comparison to 58.5% of children in Enfield as a whole.

Language differences can compound difficulties of generic dysfunctional communication between GPs and patients, with implications for patient safety.

Mental Health – National research shows that people from black and ethnic communities may face increasing difficulties including higher rates of mental illness in some communities, and problems with access to the right care and treatment, but they are less likely to have mental health problems detected by a GP. Enfield has a higher percentage of poor mental health in the 16-34 (23%) and 55+ (18.5%) age groups compared to London and Outer London (16% in 16-34 years and 13.3% in 55+ years). Local survey data shows that Enfield would appear to have poorer low level mental illness in comparison with other London Boroughs, for the following categories: women, the 16-34 age group, and the 55+ age group. It should be noted that people from the Caribbean community are often misdiagnosed and do not receive appropriate culturally sensitive treatment.

Life Expectancy – There is a significant life expectancy gap between deprived and more affluent wards within the Borough. Between 55% and 60% of this life expectancy gap is accounted for by mortality due to circulatory disease (coronary heart disease, heart failure, stroke, and other cardiovascular disease). There is evidence that the gap is widening for both men and women.

Heart Disease – According to McConnell (2013), in Enfield social inequalities in stroke are persistent, and premature death rates in the most deprived areas are around three times higher than in the least deprived. Nearly 40% of men and more than 30% of women in England have high blood pressure, a key risk factor for having a stroke. Half of people with high blood pressure are not receiving treatment. Parts of Enfield have some of the worst rates of stroke and heart disease in England, new figures reveal. According to the South East Public Health Observatory in 2011/12 there were 248.5 people admitted to hospital suffering from coronary heart disease for every 100,000 in Enfield’s most deprived areas, such as Edmonton and Ponders End. The average for England was 198.3 patients per 100,000 people. During the same period there were 137.7 people per 100,000 admitted to hospital with a stroke in the most deprived areas of Enfield, compared with the UK average of 89.5 per 100,000 people. The figures reveal huge inequality between the wealthiest parts of the Borough, where there were 97.2 people per 100,000 suffering from a stroke and 139.1 patients with coronary heart disease during the same period.

Smoking – Smoking prevalence in Enfield is approximately 20% compared to London and England average of approximately 22%. However, in the Turkish population, smoking prevalence is estimated at 45% for women, and 55% for men.
Inequalities in Upper Edmonton

A unpublished report by Euan O’ Neill (2013) sets out an evidence-base that highlights inequalities within the Borough of Enfield, as research in this area suggests that Upper Edmonton is more deprived when compared to the rest of the Borough. Geographically, Upper Edmonton is situated in the southeast corner of the Borough. Despite it being adjacent to the North Circular road, the transport infrastructure is weak; tube and rail services are sparse and so the area relies almost exclusively on bus services. Demographically, Upper Edmonton is largely populated by relatively young BME communities with a high birth rate, which are among the poorest in England (among 10% of the most deprived). There is also a high percentage of unemployment (6.7%) and a high percentage of benefit receivers (one fifth of the overall ward population of 17,651). Levels of crime are high when compared to the rest of the Borough. In terms of health, Upper Edmonton is subjected to sharp inequalities when it comes to life expectancy. While the life expectancy for men is at 75.5 years, which is about two years lower than the rest of the Borough, for women the discrepancy is about 6 years (76.7 years as compared to the Borough average of 82.7 years). It has been observed that the life expectancy gap between women in Upper Edmonton and those living in the best performing ward in Enfield currently stands at the shocking figure of 13 years.

Specific health concerns in Upper Edmonton range from alarming levels of childhood obesity, which are among the worst in England, to low rates of child immunization and pregnant women tend not to consult doctors until later in their pregnancy. Although teenage pregnancy rates have dropped in recent years, they remain above both the national and Borough average. Causes of premature death include strokes, cardio-vascular diseases and respiratory diseases such as COPD whilst smoking prevalence remains high. Moreover, the percentage of people with diabetes in Upper Edmonton is significantly higher than the national average at 6.3% for diagnosed diabetes and 1.8% for undiagnosed diabetes. In terms of mental health, there is a disproportionate number of people affected in Enfield when compared to the national average, in particular, with regards to Alzheimer’s disease and Schizophrenia.
Findings from the Fieldwork

Enfield REC undertook a research project on behalf of Middlesex University aimed at ‘assessing the barriers to accessing healthcare in Enfield.’ The research formed part of a joint investigation into the extent to which local providers of healthcare and health advice are able to cater for minority and vulnerable groups and the extent to which new bodies and structures implemented, as part of the NHS reform, are engaging with equality legislation and are able to offer mechanisms to implement it.

This report presents the key findings of research undertaken with the following main patient groups in the London Borough of Enfield:

- Elderly people
- Women of reproductive age
- Young people with learning disabilities

The rationale for selecting the above three patient groups originates from research undertaken for the Fundamental Rights Agency Project (2011) cited earlier, whereby these particular groups were seen as at risk of multiple discrimination (in terms of ethnicity, gender and age) in their access to healthcare. Information was gathered by holding both one-to-one and group interviews with individuals from the relevant patient groups, and discussions with staff and representatives of key community groups based in Enfield that cater for these groups. Additional information was collated through a questionnaire that was circulated to their users and clients.

Elderly people

Information was collected from interviews held with staff and users of the community groups mentioned below, together with a focus group held in July 2013. In addition 12 questionnaires were completed by elders. Community organizations where the fieldwork had been carried out include:

- Enfield Somali Community Association (SECCA)
- Enfield Saheli (women’s group of all ethnicities)
- Naree Shakti (Asian women’s group)
- Tamil Relief Centre (TRC)

Barriers identified

1. Language

Lack of English language was the most prevalent barrier identified to accessing healthcare in this patient group. Problems encountered included miscommunication, late or even misdiagnosis. When choosing a GP the main factor considered was finding one who spoke their own language and people were prepared to travel long distances for this. Language issues were also a barrier in elders benefiting from specific preventive campaigns. One example of this is Bowel Cancer Screening, where people over 60 are sent do-it-yourself kits by the NHS with instructions on taking
a sample of their own stool and returning it for analysis. Many reported that the instructions are complicated and difficult to understand, hence, “they do not bother.” Community organisations identified this as an issue and explained the importance of the campaign and how to use the kit to their users. This has proved helpful in reaching some people, although many will still not be reached or refuse to undertake the test anyway. Many find the appointment system difficult because they have to call in at specific times to make appointments. Outside of these times there is a telephone service in English which elders cannot understand and so they have to rely on family and friends to make the call on their behalf. Appointments for the day they need them or soon after are often gone by the time they get through so they have to make several attempts. Eventually, they are reluctant or embarrassed to ask for the favour again, resulting in them not being seen promptly and getting the help they need, which could lead to their symptoms or condition worsening.

2. Cultural Barriers

According to the fieldwork conducted in Enfield, there is reluctance by the Somali community to use mainstream services because of bad experiences of the NHS. Traditional advisors and healers are often used instead of GPs and other medical outlets because elderly people have more trust in them and prefer tried and tested remedies that have been handed down through generations. In contrast to some Somali elders, Asian elders are particularly respectful of GPs although they too often use traditional healers and are not aware of additional services offered by GPs and other medical outlets. They would like to have more appointment time with their GP in a single slot to get holistic advice, rather than having to arrange multiple visits for their different ailments. However, GPs do not have the capacity to deal with more than one or two problems per appointment and it may be a while before the patient gets round to making a further appointment. This again, could lead to symptoms getting worse.

Case Studies

a) One individual had the wrong leg operated on due to miscommunication.

b) One elderly lady with a slipped disc did not seek treatment through her GP because she was told by traditional advisors that she would become paralysed and incontinent.

Key issues for Elders:

- Language is a prominent barrier for elders in accessing healthcare and when choosing a GP. They are prepared to travel long distances to find a GP who speaks the same language.

- Many elders face difficulties when booking GP appointments, as the telephone service is in English and they have to rely on relatives and friends to make the call on their behalf. This is particularly difficult as it often takes several attempts before an appointment can be booked.

- Health messages and preventative campaigns, specifically targeted at their age range, often do not reach this patient group because of language issues.
• Many elders report suffering from long term chronic conditions such as diabetes, heart disease, and hypertension and feel they are often placed on long waiting lists for referral by their GP to other services, such as physiotherapy. Many also report isolation issues.

• There is reluctance by some communities, particularly the Somali community, to use mainstream services, relying instead upon traditional advisors/healers.

Women of reproductive age

The information below is based on interviews held with staff from:

Enfield Somali Community Association (SECCA)
Enfield Saheli and Enfield Children & Young Person’s Services (ECYPS),

We also conducted a telephone interview with a retired midwife to explore the perspective of her female clients/users. Additionally, this patient group completed 15 questionnaires.

Barriers identified

1. Awareness

Of the 15 women who returned their questionnaire, 14 individuals indicated that they were registered with a GP. One individual, who described herself as an asylum seeker, was not registered with a GP and, therefore, not receiving any medical services, however, she expressed a wish to become registered. Seven women indicated that they did not know of any specific services offered for women by GPs and the NHS or about services available for their children. They are not aware of information about pregnancy or general women’s health. Others were aware of basic services, such as smear tests, family planning, baby clinic, antenatal and postnatal clinics. Twelve out of 15 women had not received any medical advice from anyone other than a GP.

Many women from BME communities are not registered with a GP. They do not know about GP services, as there is no such service “back home.” Many women and their partners are new arrivals and do not know people who can help them or where they can go to access help. They are still trying to settle into the community and their new surroundings and getting used to the language and system here. It is more important to them to concentrate on their immediate basic needs, such as accommodation and employment, which are seen as primary issues, while health is seen as a secondary issue. They do not seek medical assistance until they actually fall ill and need treatment, at which time they go straight to a hospital where they expect to be seen and get the help they need, as this is how the system works in their own country. This causes major problems for A & E as they become increasingly overburdened.

In Somalia, most women do not go to hospital to give birth—their babies are often delivered by a family member or Imam. Services such as antenatal clinics and classes are not used, especially as many women fear they may be told they will need to have a caesarean delivery. Those who do go to hospital refuse to have a caesarean if they are advised to have one, due to their belief that once they have this procedure they will not be able to have more children or may become disabled.
People are not aware of services provided by other NHS outlets, except chemists where they collect their prescriptions. They are often not registered with dentists either but only look for one when they experience toothache. They are, however, reluctant to go to the dentist because it is too expensive and they may not be aware that they could be entitled to free or subsidised treatment. Enfield Saheli’s Domestic Violence (DV) worker said her clients are registered with GPs but they do not have any idea about the services they offer, apart from the usual consultations for illnesses.

2. **Language**

Language is a major barrier for women when accessing health services and attending GP appointments in particular. Although Language Line is used by some GPs, women still rely on family members to interpret for them and find it particularly embarrassing, especially if having to rely on a young child or male teenager, to explain their symptoms or problems to the GP or other practitioner.

3. **Cultural barriers**

In some cultures, women believe that pregnancy is normal and natural and that God will see them through it. They do not inform their GP or Health Service about their pregnancy until they are at the very late stages of it, approximately 30 weeks or even later, when they are almost ready to give birth. This means that the GP/midwives have no access to their medical notes or history. Many women from African communities are escaping from war as refugees and do not have family to turn to for help and advice. It is rare for them to attend antenatal services and, therefore, any complications in pregnancy are not being picked up. Abnormalities and serious conditions, such as high blood pressure and pre-eclampsia are not detected early enough or at all, resulting in complications suffered during the pregnancy and childbirth. Consequently, there is a higher mortality rate for the mother and the child.

With regards to domestic violence (DV), one of our research participants was a DV worker. She refers individuals who come to her for emotional support to Saheli’s counselling services. Sometimes she receives referrals from other organisations and self-referrals also. Ongoing one-to-one support for physical or mental abuse problems is provided either by offering face-to-face appointments at the office or over the telephone. The women themselves do not reveal that they are suffering from DV because of the stigma attached to it, although they are articulate in English. Some clients are referred to Enfield Saheli through teachers, who can often spot the signs of DV taking place at home by the child displaying symptoms of depression or anxiety at school. To confirm their suspicions, they would speak to the children or call the parents in to the school. These families are not getting help or counselling of any kind and the DV worker is not aware of any culturally sensitive services she can refer them to.

With regard to young girls, mothers approach Enfield Saheli about problems they are experiencing with their daughters, especially if the relationship between them is problematic. Single parents particularly need help. Young girls have tremendous peer pressure but are also faced with other pressures in their home life. Enfield Saheli’s DV worker can provide support for the mothers, but the young girls are reluctant to reach out for help, especially because the mothers or older women are seen to be the clients and the girls are worried about confidentiality. This has an impact on their emotional and physical well-being and currently there are no culturally sensitive services for them.
The DV worker is trying to build links with schools to make young women aware of her services. However, because she only works part-time, she can only provide a limited service.

Female genital mutilation (FGM) is common amongst some African communities. It is a very delicate subject, which is thought of as ‘taboo.’ Women do not want to disclose it and rely upon traditional medical advisors, rather than the NHS. Cases of infections from FGM are reported very late, preventing timely treatment.

4. Inadequate service provision

Enfield Saheli’s DV worker contends that in her experience with clients, most GPs do not notice any emotional issues or problems, because they are focusing only on the physical symptoms. Hence, the fact that emotional aspects could be impacting on their physical health, are not being recognised. Some clients have been going to their GPs for years, but their DV issues have not been detected. When they do approach GPs about emotional issues, more often they are just prescribed anti-depressants and sleeping pills, rather than being referred to counselling services. The DV worker also stated there does not appear to be any help available for Asian men either to deal with their emotional and mental health issues and so the pressure builds up within the family.

Case Studies

a) Two teenage girls from the Turkish community needed advice on where to go for free pregnancy testing. They were reluctant to approach anyone from their own community group as they were scared and felt they may be frowned upon due to having sex and becoming pregnant at such a young age and whilst unmarried. They were also worried about confidentiality issues.

b) One woman reported that she had a bad experience in child birth as the midwives were reluctant to give her an internal examination. She complained about receiving a slow service when giving birth to her last two babies, saying that she was already in the final stage of delivery and pushing out the babies, before the midwives arrived to assist.

c) One client suffering from DV tried to commit suicide but the GP thought this was the result of mental health issues rather than realising that the domestic violence could have contributed to this.

Key Issues for Women:

- BME women tend not to be aware of additional services offered by GPs, even if they are registered. They are even less aware of the services of others, e.g. dentists, physiotherapists, chemists.

- Women from some communities, particularly African communities, newer arrivals and refugees, are not always registered with GPs due to lack of knowledge. Many seek help from hospitals when they become seriously ill or presenting acute symptoms.
• Many women do not seek support when pregnant until the very late stages of pregnancy. Amongst some communities, it is felt that pregnancy is a natural process and hence there is no need for assistance until the delivery stage. Hence, any problems or complications are not picked up or treated at an early stage.

• Signs of domestic abuse or emotional mental health issues are often not picked up by GPs, hence serious emotional issues go unnoticed. This is particularly exacerbated due to GP appointment times being too short and not allowing enough patient time.

• There are no specific or cultural services for women, apart from those provided by some community organisations. However, young girls in particular are reluctant, because of confidentiality issues, to approach community groups, especially when it comes to pregnancy and sexual health matters. They feel that organisations are catering mainly for the older generation, rather than younger age groups.

• Language barriers pose particular problems for women seeking medical assistance on sexual or reproductive matters.

Young people with learning disabilities

The information below is based on discussions with staff and users at a health drop-in held by One to One and interviews with three young people with learning disabilities aided by the completion of a questionnaire, with the help of their carers and EREC staff.

Barriers identified

1. Awareness

The staff member at One to One pointed out that they do not have many members under the age of 30 and from a BME background, although efforts are being made to engage with them. She felt that the majority of their users do not know what services are offered by GPs or about other health services that are available. Moreover, the staff member said they rely heavily on people who care for them and whom they can trust, like family members, who may themselves have limited English and are also not aware of what help is available. Their users also receive assistance on health matters from people they see regularly, such as home care workers or from staff at day centres. In particular, they have very little awareness of the recent structural changes to the NHS as does the One to One organisation itself, including how the changes might impact on their client group.

The three young people with learning disabilities that were interviewed all spoke English and were registered with a GP. They are aware of some of the services provided by their GP, such as blood tests and blood pressure checks, and that practice nurses are attached to the surgeries. Most stated they are unable to arrange appointments with their own GP and dental appointments, and collect their prescriptions and rely upon their carer to do so on their behalf.
2. Cultural barriers

The SECCA representative reported that many Somali families are not getting the help they need because they do not know what services are available. Also, some people go to alternative practitioners from their community for cure. Sometimes schools pick up issues, such as autism, and then families get help/referral. Families do not want to access mainstream help because they think their children might be abused. Children do not get assessed; therefore they do not receive the necessary help at an early stage or at all.

**Case Study**

One parent said that her GP had no real knowledge of issues concerning special needs or learning disabilities that her child suffers from. No specific service, assistance or advice had been provided to her by her GP. She found it hard to get proper diagnosis of her child’s disability. The child is now seven years old and has finally been diagnosed with late development and possibly as being on the autism spectrum, however, the parent still does not feel she has been given enough information about this and does not quite understand the meaning of the condition. She felt that her child’s school was more helpful and assisted her to get appropriate help for her child, who now attends a special school. The child’s general health is also a matter of concern as the child suffers from fits sometimes caused by high fever, but more worryingly, even without fever. The doctors are now suggesting that the fits may be related to epilepsy, but diagnosis is still not confirmed. The parent feels frustrated that every time she calls for an ambulance, or attends the hospital A & E or other services related to her child’s health, she has to repeat the same information over again. She expects these services to already have access to this information, and finds it especially difficult during emergency situations, in case she misses out vital medical history whilst feeling anxious. In her experience, record keeping, attention and care at the hospital are often very bad. On two occasions, her child was given a double dose of medicine in error, which directly contributed to the worsening of her condition at that time. She is now so frustrated and has resorted to obtaining help privately for her child and is even considering ‘going back home’ to seek help from a faith healer.

**Key Issues for Young People with Learning Disabilities:**

- There is a heavy reliance on carers, formal professionals, family and friends to help young people with learning disabilities to access healthcare and support. However, many family members and friends often also lack information and face language difficulties themselves.

- Community representatives are not aware of recent NHS changes and the implications on their users.

- Families are not receiving the help and support needed for children with special needs as these are not detected early enough.

- Cultural issues are a barrier when trying to access appropriate help from mainstream providers and people prefer to use traditional advisors/healers who may not be qualified.
• Parents are frustrated when having to repeat at every appointment the same information about their medical history, especially during an emergency, when they may not recall important information.
Overview of Key Findings from the Qualitative Interviews with the Three Patient Groups

The main barriers to accessing healthcare that were common to all three patient groups were general awareness of services and knowledge of the NHS system, and language and cultural barriers.

General awareness of NHS services

There is concern amongst some community representatives that newer arrivals and those who are not in contact with community organisations are not registered with GPs due to a lack of awareness or for cultural reasons. Hence, they are not receiving any services until they encounter acute health problems. Even those from the more established communities, although registered with a GP, needed help to do so. They turn for help to friends and family, who are already settled or to community groups they are involved with. There appears to be a huge lack of knowledge and awareness of services offered by GPs and other medical practitioners. The role of community groups is crucial in passing health messages on to the communities they cater for, particularly when health promotion and prevention work is carried out. There is very little awareness of the recent NHS changes, even amongst community representatives.

Many BMEs do not understand the service provided by hospital A & E and often use it when they should be making an appointment to see their GP. This could be because they may not have had a GP in their own country and were regularly at hospital for their problems. Many people experience difficulty getting a GP appointment, especially when they have to ring during specific times. This is a particular problem for all three patient groups, who rely on others to make their appointments owing to language difficulties. GP appointments are not always available when needed and people end up at Hospital A & E. People are also not aware of where they can access medical assistance outside of GP hours so again turn up at A & E. This results in over-use of Hospital A & E amongst the BME communities.

Language and cultural barriers

There is an ongoing need for help in getting access to services because of language barriers. Language difficulties particularly affect elders and women who are not getting timely help to resolve their issues. They appear to have a strong reliance on traditional healers/advisers instead of approaching NHS care, either because they are unaware of services available to them, have had a bad experience of the NHS, or due to other cultural reasons.
Focus group discussion with health stakeholders in Enfield

Inequalities and barriers to access

In terms of barriers to accessing healthcare in Enfield, four key narratives emerged, namely, language and cultural barriers, knowledge and awareness, lack of appropriate data and analysis and lack of political will and leadership. Each of these four narratives will be discussed in turn, drawing on excerpts from the stakeholder’s focus group to highlight important issues of concern among health professionals in the Borough.

1. Language and cultural barriers

Language barriers were identified among local communities who do not possess English language skills to enable them to effectively access the health service, not just younger migrant communities but also older more established migrant communities. Hence, there is a need for health institutions and policy makers to recognise this and facilitate the provision of ESOL (English for Speakers of Other Languages) since “the ESOL provision is a major issue in relation to the barriers to every kind of interaction including with the health service.” These barriers are further compounded by the reported lack of interpretation and translation support in local GP practices which inhibit access to patients where English is not their first language. The example cited in the group discussion was the perceived loss of funding for Language Line with the abolition of the PCTs and the lack of awareness about who has responsibility for funding this service in Enfield, whether it is NHS England or the GP practice. Even where Language Line is provided in GP practices, access is still an issue since the limited appointment times with the GP mean that it is currently not feasible to “accommodate a 10 or 20 minute appointment on the line with Language Line,” and so patients in need of this service are being turned away.

In terms of cultural barriers, one of the practice managers had observed that patients from minority ethnic communities tend not to initially register with a GP practice but, instead, they only present themselves to the GP when they have a health problem and require a prescription or a referral. The example given by the practice manager identified migrant communities from Eastern Europe who experience healthcare provision as a “one stop shop” in their home countries. Here, raising awareness and educating minority ethnic communities about the need to register with a GP, and making the GP practices more visible and accessible to migrant communities as well as seeing patients more quickly, would encourage greater participation by these communities in local healthcare services. Another example cited in the group discussion related to older minority ethnic women who are more involved with nurturing their families to the detriment of their own health problems, which acts as a barrier to accessing healthcare, “so if they have a health problem, they tend to put it off…it really is a cultural issue.”

Another issue that emerged during the group discussion was the lack of translation of certain health conditions in some minority ethnic languages, which inhibits awareness and understanding among Black, Asian and minority ethnic (BAME) groups. This example was given in relation to the Connecting Communities in Enfield project, which is an awareness-raising service that targets BAME groups about dementia and attempts to reduce the stigma attached to this condition. Similar comments emerged around the notion of mental health, in that some groups, for example, African
Caribbean communities, do not fully understand what constitutes mental health, coupled with their poor experiences of mental health services and lack of professional understanding about these experiences, suggesting that the issue is not one of language but rather cultural barriers that exist in accessing healthcare.

Another important, yet, related point raised by some of the Enfield stakeholders was that cultural barriers should extend to institutions as well, whereby service providers are seen as adopting an ethnocentric approach in healthcare provision which becomes a problem when people from different cultures interact, as one stakeholder stated:

“We insist on using our language, our cultural norms and our methods of looking at things and expect other people to fit into those. It’s not that those communities have a problem; we have a problem meeting those needs.”

Moreover, the local population is constantly changing and so it is important for health services to change also and adapt to local needs in order to ensure that equality issues are being addressed. Using the example of the CCG, one stakeholder commented:

“How can we ensure that the CCG deal with the equality issues properly, and how do we make sure they actually consult and find out what the barriers are in accessing services?...certainly in terms of registering with a GP.”

Thus, there are calls for institutional change in terms of the culture of service provision, in order to effectively remove barriers to accessing healthcare. Having said this, stakeholders in Enfield also recognise that institutional change invites challenges since it requires services providers “to reflect on their own practices and to make changes and to question some of their preconceptions about the way that they work.”

Alongside the ethnic dimension of health inequalities, some of the stakeholders were interested in addressing lifestyle choices among communities in socially deprived areas, for example, reducing smoking and staying out in the sun to absorb vitamin D. The answer was to adopt a model similar to the ‘delivering race equality in mental health’ strategy implemented in other Boroughs, whereby, health services in Enfield could work with community groups to talk about health and lifestyle issues among their minority ethnic communities. At the same time, however, stakeholders identify that secondary healthcare services have no funding powers to engage this type of work with the voluntary and community sector leading to a deadlock in addressing community health issues, as the following excerpt indicates:

“So unless the voluntary sector and the community sector is able to articulate those needs to get the system to respond, you are stuck in a situation where it’s a conversation that’s going, “we are saying it, you’re saying it and it’s passing the buck” because you are saying “why aren’t you doing it?” and we are saying “well we can’t, why are you not doing it?””
2. Knowledge and awareness

Many minority ethnic communities in Enfield lack knowledge about the services that they can access at GP practices or even how to access these services, as the following comment illustrates:

“They don’t actually know what services a GP provides and when I suggested maybe they can talk to somebody else in the GP practice, like a nurse, they just don’t seem to understand that there are other things a GP can provide apart from an appointment with the GP themselves. There seems to be a lack of knowledge about what actually people are able to access in practices.”

Of importance, the health professionals in Enfield expressed concern about the necessary ethnic minority assessments being ineffective, as they report: “ethnic minority assessments are often not done or done extremely poorly,” particularly by secondary care services. Lack of such data invites gaps in knowledge about service provision and the impact of changes in service provision, making inequalities in healthcare access difficult to monitor.

A strong sentiment among key stakeholders in Enfield is that “inequality continues to perpetuate” in healthcare provision since the current NHS model is flawed and uninformed, applying universal services to an unequal population, as the following comment vehemently demonstrates:

“We provide the same standards to everyone and although we pay lip service to the idea of different needs we actually focus on the idea of standardization, because it’s easy, it’s easier, it’s more manageable and the policy framework increasingly encourages us to do that.”

3. Lack of appropriate data and analysis

A key issue that emerged during the focus group discussion was that the present healthcare policy framework no longer provides an incentive (financial reward) for GPs to record ethnicity data or to use such data to respond to specific healthcare needs, such as Thalassemia or sickle cell among certain minority ethnic communities, as the following responses illustrate:

 “[In] the GP contract now, ethnicity recording is not a must anymore and ethnicity recording has been scrapped this year and that includes with it language. So unless practices are doing it on their own back...there is no onus anymore, there is no incentive anymore for a GP practice to collect ethnicity data...there was only one point allocated to that achievement, and one point is nothing when you have maybe 55 points. It was only one point so there wasn’t ever a big incentive.”

“So that means the systems loses all ability to respond to ethnic difference?!...So how can you actually even begin to plan for the patient?”

Although, there is no national incentive to collect ethnicity data, the practice manager did acknowledge that most local GP practices do have mechanisms in place to record such data, for example, through registration forms. Essentially, however, it is not so much the recording of ethnicity data that is of key importance but the way in which such data are analysed, whether at the
practice level, Borough-wide level or City level, which would capture the specific health needs of minority ethnic communities. Thus, calls for Joint Strategic Needs Assessments (JSNAs) in Enfield to focus more in-depth analysis of the needs of different ethnic groups: “future JSNAs should look into the needs of various subsidiaries within the ethnic population.”

Moreover, by adopting an approach that is “increasingly blind to ethnicity,”” it is questionable whether the NHS is dealing with community specific health issues (e.g. thalassemia and sickle cell anaemia) in a timely manner. Even at a recent local conference on health inequalities in Edmonton, it was noted that the discussion of health inequalities in socially and economically deprived wards was silent on issues of ‘race’ and ethnicity, as the following observation illustrates:

“They talked about certain amount of over representation in sort of death rates etc. in certain wards, we all know what kind of people live there, but nobody mentioned their ethnicity, it was sort of cleansed out, not anybody mentioned race, nobody mentioned ethnicity, it was just like in certain areas of the Borough, this is what’s happening it’s inequalities, but nobody defined the inequality.”

There is also a lack of accurate reporting of the relationship between ethnicity and inequalities in life expectancy data in different parts of the Borough. Stakeholders report that where there is an ethnic dimension, it highlights ‘white other’ groups (e.g. Turkish, Cypriot and European groups), which is considered a “senseless category” in terms of data analysis and reporting and, hence, they highlight the need for more research and drilling down of the data to obtain “further segmentation of the ethnic population” in the Borough. Although the NHS has “tons of data,” the present discussion clearly demonstrates that current analysis of data is inadequate and not regularly accessible which acts as a barrier to understanding inequalities and access to healthcare in the Borough, as the following comment exemplifies:

“What we have is we know the number of people presented to us with the particular health condition, we might even know the ethnicity of people with that health condition, what we often lack is an idea of the difference between prevalence and incidence. So is it that we’re seeing everybody who has that condition, or are we only seeing a proportion and that is at the core of the health inequality scope and some of that is around you being able to present information to commissioners in ways that are easily understood and powerful.”

In terms of the data being used to inform commissioning decisions, the health professionals did recognise the financial constraints that CCGs are operating within and, therefore, savings need to be made and health programmes prioritised. At the same time, however, the Enfield stakeholders emphasised the importance of using the data to analyse “how our decision is going to impact on different equality groups and if we can do further segmentation of the ethnic population by using our ethnographic data, that will be more effective.” In this instance, CCGs and service providers need to work together to ensure that equality impact assessments are conducted effectively and the right groups are being consulted in the locality.

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2 We recognise that “race” is a social construction (rather than a naturally given phenomenon) that acquires different meanings in different political, historical and geographical contexts.
Moreover, some of the health stakeholders felt that equality impact assessments should be included in the Joint Strategic Needs Assessments (JSNAs). In response, the inaccessibility of JSNAs was raised in the group discussion in terms of the amount and nature of data presented and the language used. Calls for a more user-friendly factsheet type format on health needs and inequalities was recommended, in order to empower and better inform local people and voluntary sector organisations in making decisions about health issues in their local communities. There appears to be promising signs of this aspiration; for example, Enfield Council was reported to be “chang[ing] its approach to assessment” to produce thematic factsheets on specific health issues.

4. Lack of political will and leadership

Stakeholders found it rather surprising that even as a result of the restructuring of the NHS and the Public Sector Equality Duty under the Equality Act 2010, the equalities agenda has not been implemented in practice. Tensions arise between prioritising limited resources of the NHS and meeting minority groups’ needs, leading to winners and losers of healthcare reform: “let’s treat as many people as best we can, for as cheaply as we can’. And if some minority interests lose out, well this is the best that we can do.”

Moreover, as identified earlier, if minority ethnic communities experiencing health inequalities are not defined in local data analysis, then how is it possible to address their specific health needs? This question invited further debate in the focus group discussion such that some stakeholders felt that further analysis and research are required to make a direct correlation between ethnicity and mortality rates in different socio-economic areas of the Borough, whereas other stakeholders concluded that the evidence does exist in the public domain but that there is no policy context to prioritise or deal with these issues, as the following comment demonstrates:

“The responsibility for addressing health inequalities is not part of the mainstream of health provision anymore. Whether Healthwatch and the well-being boards are going to make a difference, we have yet to see, what they’ve tended to focus on is structural issues, “are you going to close such and such hospital,” “is our A & E going to stay open.” They are not looking at health inequalities either…there are no powerful drivers for addressing health inequalities, no communities that are up in arms, no incentives in terms of QOF [Quality and Outcomes Framework] to address it and there are no powerful bodies at the national level to say we want to see targets, we want to see achievement in this area, but it’s not lack of evidence.”

Talk of health inequalities and identifying specific communities invited further debate among the stakeholders, for instance, where to start in terms of addressing inequalities and barriers to accessing healthcare: is it from the grassroots up or from the top-down? Some stakeholders felt that pressure for change should come from the bottom up, from local communities themselves, whereas, other stakeholders felt that the key issue for change is leadership from the top, in terms of acknowledgement that these issues matter, that they make a difference to people’s experiences and access of healthcare services, which in turn will mobilise communities to feel empowered. Indeed, stakeholders report that lack of political will and leadership to address equality issues is nowhere more evident than the Coalition Government’s dismissal of equality impact assessments. Lack of leadership in the health inequalities agenda will invite feelings of disempowerment and powerlessness, as the following comment identifies:
“If you completely white-wash it out, what’s going to happen is people are going to say, what’s the point, what’s the incentive, why am I doing this particular piece of work when nobody’s going to acknowledge it or it’s not really important to the people at the top.”

Thus, developing work at the grassroots on health inequalities among BAME communities requires the voluntary and community sector working in partnership with groups preparing JSNAs in the Borough “to [inform and] understand what the issues are” in order to drive local healthcare policy and services.

Gaps in service provision

A major gap in service provision that relates directly to access is adequate signposting and the provision of information since “there is a lot of learning to be done [about] who is responsible for what so some kind of route map through the services” is required. As a result, there are urgent calls for a “single point of contact” to access information about the different services available and who to go to and where, which would reduce barriers and inequalities to accessing healthcare in the locality. At the same time, however, a concern expressed by the health professionals is that promoting or facilitating access should not be equated with burgeoning the system with more demand, particularly given financial constraints in the health service, but, instead, setting aside a collective pot of money to ensure “demand to be more appropriate [which] would probably actually save money and save lives.” Good examples of single point customer contact centres were identified in local government in terms of housing, social services and environmental health, “just go to the customer contact centre and they will direct you around the system.” Yet, a similar service is absent in the NHS. In response, the practice manager identified that GP practices have been responding to this challenge through the minor ailments scheme which is rolled out across practices in the Borough which is proving fairly effective by “giving more access to patients…to meet demands and deal with patients.”

Another important gap in service provision is the need for equality of provision and monitoring of private sector providers, ensuring that they “deliver equality to the local population…[and] government in ensuring that where there is a contract there is compliance.” Healthwatch and the Care Quality Commission (CQC) are viewed as having a critical role in scrutinising the services of private sector providers and making them accountable for use of resources in the provision of NHS healthcare. Of particular concern, is that the CQC must seek to address its new responsibilities and implement the equality agenda. Of importance, the health professionals see partnership working as the way forward in terms of ensuring access and equality of provision in healthcare, especially given the limited resources of, for example, Healthwatch Enfield, as the following comment illustrates:

“We certainly need to leverage by working through other organisations and trying to...what we were saying about the culture of access...get it right. Find where it really really works and getting everyone to work in that direction. We have very limited capacity at the moment but that doesn’t stop us asking questions.”

Enfield Healthwatch reported that they have not discussed the issue of tackling access to healthcare as yet. However, NHS England is viewed as the main body responsible for ensuring access and
effective outreach among GP practices: “They do monitor and scrutinise access very very closely, appointments, cancellations, DNAs, un-booked appointments, so all those questions are being asked.” This led to discussion about one aspect of the Public Sector Equality Duty to “promote equal opportunities” which is seen as fairly challenging for healthcare services since: “we need to look at individual groups and start to say well actually we are going to do something extra for you and that is the point at which the NHS starts to struggle. It is about giving preferential treatment to certain groups.” However, these are the services that are perceived as “targets for funding cuts.” The health professionals cite an example of the learning disabilities nurse working across the Enfield hospitals which many feel is a vital service that can be adopted as a positive model in liaising with other vulnerable groups, such as BME groups or people with mental health issues. However, there are reports that this service will be terminated due to funding cuts, although, the group is informed that transitional funding is provided for this service until a cost benefit analysis can be carried out since “the service is being used but we haven’t got the data at the moment to say what would be the opposite, what if there was no service, what would be the cost?” This reinforced the need for an equality impact assessment to demonstrate that the learning disabilities nurse and other similar services are needed to promote the health of local vulnerable communities, as the following comment illustrates:

“It makes a huge difference in the lives of patients that is being served, so and I think that is where groups need to actually use their leverage to say we want an impact assessment done for this particular service because it is not a lot of funding, we only have one nurse that is being shared and she be funded by the establishment.”

A final issue that emerged in the group discussion in relation to gaps in service provision was the lack of premises in Enfield in terms of having, for example, more buildings or sufficient consultation space in GP practices.

**Training and capacity building**

Training and capacity building are seen as key solutions to reduce inequalities and improve access to healthcare in Enfield and suggestions put forward centred on awareness raising, enhancing data analysis skills, assessment training, information provision and working in a joined-up way, as the following discussion illustrates.

Of importance, the health professionals feel strongly that equality and diversity training should be provided for top-level management/partnership boards in the health service, in order to raise awareness about the meaning of equalities and what this entails in healthcare provision since “they have the power and the authority to make sure things get done.”

Building the capacity of community organisations was seen as important among the Enfield stakeholders, particularly in terms of being able to interpret, analyse and respond effectively to data in the public domain, as the following concerns were relayed:

“The NHS is awash with data…but it is kind of patchy, how do community organisations, how do Turkish Cypriot organisations read data and respond to it in a structured manner. What is the capacity to do that and how do community
organisations get together to do that analysis? Do they do it under the umbrella of other organisations or does there need to be some ‘Enfield Peoples Forum’, ‘Peoples Data Forum’ whereby they read the data and know what is going on?…if there isn’t the capacity in the community sector to read data and respond then sadly with the best will in the world the management of the NHS will assume everything is okay.”

Calls for capacity building among the community sector are seen as all the more urgent given “the specific public sector duty to publish data on outcomes” and a corresponding lack of a proactive response from community organisations, especially since “that’s data that is easily understood and points to serious inequalities but nobody ever challenges it.” There was even a low uptake of equalities training in the community sector; this was evidenced when one of the health professionals offered community workshops on the Equality Delivery System (EDS) reporting that “I was underwhelmed.” The health professionals highlighted the importance of access to information in the public domain and providing local communities with the skills to be able to engage with the data, identifying the “information route” as a way to make public sector organisations accountable and their decision-making transparent.

NHS England was identified as a key body in ensuring the delivery of equality in the NHS since they are responsible for rolling out the Equality Delivery System (EDS) to local NHS organisations, a toolkit to assist in the assessment of NHS Trusts in terms of improved services and healthcare outcomes for people with protected characteristics under the Equality Act 2010. However, training is needed on how to carry out these equality delivery assessments, as indicated below:

“Part of what that new system says you have to do is, we as Trusts, mental health, learning disabilities, we don’t assess ourselves, we ask all of you to come in and assess us based on the evidence of outcomes for what we have done…when you then ask communities to come and assess you and you actually got to get responses from them, it would be useful to have a particular type of training at this stage so that people actually know what they are coming to do when they come to assess us.”

Alongside this discussion, the health professionals also identified a resource issue in being able to help all organisations that have asked to be assessed since “it is actually time consuming.” One suggestion raised to “put information out” in an effective way was through the quarterly meetings that senior members of staff at Enfield Council have with EREC, where data on, for example, mental health services is presented, questions are asked and feedback is immediate. In these contexts, the Council produces data on employment or housing and EREC will scrutinise the data, identifying that “it has been one of the most fruitful things that we as EREC have ever done.” Through such processes, there are opportunities to scrutinise the delivery of healthcare services under the EDS, which would be one way forward in advancing an equalities agenda in healthcare provision. Indeed, one example of good practice is that service managers have been given the opportunity to attend the Council-EREC quarterly meetings and consult with local BME communities about their equality and impact assessment, “to give them the information that will help them plan their development services.”

The stakeholders recognise that there is limited capacity to do the above across the full range of health issues “so you have to be very selective about that.” In response, some of the health
stakeholders saw the potential of working “in a joined up way” to increase the capacity to disseminate information and data on local healthcare services, as evidenced in the following excerpt:

“If Healthwatch is doing something and EREC is trying to do something then maybe it is better to get together and try to prioritise who is going to respond where and how and similar views maybe, in certain places so I think it is important to actually respond.”

Indeed, the Enfield stakeholders felt that the proposed ‘Enfield People’s Forum’ should address not only ethnic minority issues but “include all the other equalities strands.” Moreover, an additional role for scrutiny panels was suggested in the group discussion, whereby senior officials from the Council and other organisations could scrutinise health data and engage with multiple equality strands: “instead of looking at equality strands separately, or protected health characteristics separately, we don’t see that you got people from minority ethnic groups who might be older, they might be young, they may be male, they may be female. This is multiple discrimination...”. This reinforces the message of intersectionality highlighted in the Fundamental Rights Agency project (2011) cited earlier.
Recommendations for Action in Delivering an Equalities Agenda in Healthcare Provision

Tackling language and cultural barriers

**GP Practices:**
- GPs should have leaflets about their services in simple language, and where possible, in community languages.
- Developing effective communication and outreach strategies to raise the visibility and accessibility of GP practices, and to raise awareness among minority ethnic communities about the need to register with a GP and the range of services that are available.
- GP practices in Enfield need to make their services/appointments more accessible, increasing appointment times to accommodate language and interpretation support as well as seeing patients more quickly, as this would encourage greater participation by these communities in local healthcare services.
- Young women need greater awareness of health services available, particularly regarding pregnancy and sexual health.

**NHS England, Government Bodies and Health Service Providers:**
- NHS England needs to raise awareness throughout the NHS about its responsibility in funding language provision (e.g. Language Line).
- More funding needs to be made available by the NHS for translating and interpreting and also improved ESOL provision.
- Increased funding for awareness raising services in Enfield to target BME communities and to improve understanding and knowledge about certain health conditions, as well as remove the stigma attached to seeking help and accessing appropriate healthcare services.
- Provision of cultural awareness and sensitivity training to change the way that healthcare institutions approach and work with BME communities, tackling prejudices, preconceptions and stereotypes and reflecting on current practices in terms of how they impact health inequalities and access to healthcare services.
- NHS England needs to review the current NHS model of delivering a universal service and its ‘indifference to difference’ approach and instead prioritise funding in tackling health inequalities and removing barriers to accessing healthcare.

**CCGs:**
- Enfield CCGs need to ensure that they adequately address equality issues and consult on what the barriers are in accessing healthcare.

Reviewing data provision

NHS England, Government Bodies and Health Service Providers:

- Policy makers need to revise the current healthcare policy framework so that it includes an (financial) incentive for GPs to record ethnicity data and use this data to respond to specific healthcare needs of BME communities.
- Proper collection and analysis of data are required at the practice, Borough-wide and City level to capture specific health needs of BME communities.
- Joint Strategic Needs Assessments (JSNAs) in Enfield should ensure that the analysis of East European, Turkish and Cypriot ethnicity data are analysed separately and not aggregated into the ‘White Other’ Census category so that health and social inequalities are not rendered invisible making it difficult to evaluate progress. JSNAs need to also ensure more in-depth analysis of ethnicity data so that the health needs of different ethnic groups are met.

Health Service Providers and the Community and Voluntary Sector:

- JSNAs in Enfield need to work towards a more rigorous methodological approach in assessing community groups’ needs and more user-friendly style of communication and dissemination, which can be achieved with greater collaborative input from the Enfield community and voluntary sector.

NHS England and Government Bodies:

- Government bodies need to recognise the importance of equality impact assessments, learn from good practice at the local level and prioritise the implementation of equality impact assessments in the policy framework of the NHS.
- CCGs need appropriate and accurate data to inform their commissioning decisions but also to ascertain how their decisions are likely to impact on different equality groups.

CCGs and Health Service Providers:

- To ensure adequate equality impact analysis, CCGs and service providers need to work in partnership to ensure that they are consulting the right groups in the locality.

Ensuring leadership in addressing health inequalities

- It is important to reignite dialogue and policy debate about ethnicity and health inequalities to move away from an ‘indifference to difference’ approach in healthcare provision and to foster a ‘culture of access’ in addressing the specific health needs of minority ethnic communities.
- NHS Trusts need to work in partnership with the community and voluntary sector to articulate and respond to the health needs of their minority ethnic communities and secure funding.
- Need to develop an NHS model that engages community development workers from the health service in reaching out to work with and educate local communities.
Improving healthcare provision

**Health Service Providers:**

- Improved signposting and information provision to facilitate knowledge about and access to different services.
- Establish a single point customer contact in the NHS.
- Health service providers need to be encouraged to promote and deliver all aspects of the Public Sector Duty, especially in terms of the promotion of equal opportunities.
- Record keeping needs to be improved so that clients’ medical history can be easily accessed by practitioners in an emergency, rather than relying upon the carer or the patient to provide the information, who may not recall important information at that time.

**Healthwatch England, Healthwatch Enfield and CQC:**

- Ensure adequate compliance by and monitoring of private sector providers in delivering equality in healthcare.
- Important to have equality impact assessments for different services to ensure funding and continued provision of health services to vulnerable groups in the locality.

**NHS England, Government Bodies and Community Organisations:**

- Funding of programmes to raise community awareness and target the health needs of BME and other vulnerable groups in the Borough should be provided.
- The provision of more space and expansion of buildings to facilitate consultation and health care provision in GP practices in Enfield.
- It is vital that the community groups who are working very hard to provide services are assisted with grants to take up work in this area to promote health services and the benefits of using them as well as preventative work.

**Training and capacity building**

**NHS England and Health Service Providers:**

- Provision of equalities training to all staff in the health service, starting at senior levels and cascading to all other levels.
- NHS Staff should receive Equality Impact Assessment training as well Diversity Training
- Awareness-raising is required for groups and their users on the NHS reform.
- Training provided for those who have been asked to assess the health service Trusts so that they know how to carry out relevant assessments.
• Provision of training and capacity building for community groups so that they have the skills to be actively involved and analyse and respond appropriately to health inequalities data in the public domain. Opportunity to set up an Enfield People’s Data Forum to take ideas forward.

• Raising awareness about the need for and importance of information to make public sector organisations in the health service transparent and accountable.

• More outreach required for disseminating information and data so that health service organisations can receive more feedback and more questions raised to drive the equalities agenda in health service delivery.

Health Service Providers and Community and Voluntary Organisations:

• Important to work in a joined up way to enhance communication and decide who will respond and how. Important to address all of the equalities strands.

• Local organisations need to tap into EREC’s Strategic Racial Equalities Forum to consult with the BME communities about ways to improve their equality impact assessments and plan their development services more effectively to meet the health needs of vulnerable communities.

GP Practices:

• Training needs to be undertaken by GPs, health practitioners and their staff on cultural issues and sensitive matters.

Scrutiny Panels:

• Need to scrutinise the data and ensure that look at multiple discrimination and not look separately at the equality strands.
References


Local Clinicians working with local people for a healthier future (2013): NHS Clinical Commissioning Group
ADDITIONAL SOURCES OF INFORMATION

- Department of Health
  The health & care system from April 2013

- BMA Local Extra – London
  Issue 3 June 2013
  www.Bma.org.uk

- London Borough of Enfield
  Getting Involved – Building a Successful Health Watch in Enfield
  http://www.enfield.gov.uk/info1000000048/contact_us/1883/getting_involved/2

- NHS Commissioning Board
  Equality Analysis – NHS Standard Contract 2013/14

- The New NHS in 2013 – What it means for you
  www.nhsemployers.org

- NHS Enfield Clinical Commissioning Group
  About Enfield CCG - Presentation Document

- Enfield Gazette & Advertiser
  Wednesday 5th June 2013 - Alarming Rate of Heart Disease

- NHS Enfield - Clinical Commissioning Group
  Local Clinicians working with local people for a healthier future – Our Commissioning Prospectus 2013 -2014
  www.enfieldccg.nhs.uk

- Department of Health - Community Mental Health Profiles 2013 Enfield

- Department of Health - Health Summary for Enfield
  www.healthprofiles.info

- EREC CEO & Chair’s meeting with Rathai Thevananth on 14th September 2012.

- EREC CEO & Chair’s meeting with Dr Alpesh Patel (Chair of ECCG) and Jo Snape (Head of Transition Enfield NHS) on 6th June 2012 at NHS Enfield, Holbrook House.

- Quarterly LBE-EREC meeting on 5th July 2012, agenda item 5 on Health Commissioning arrangement presentation from Jo Snape Head of Transition Enfield NHS and Dr Tim Fenn Enfield CCG Representative.

- EREC AGM – Presentation on “Changes to Local Hospital Services” by Anita Grabarz, Communications lead for the Barnet, Enfield and Haringey Clinical Strategy on 11th July 2013.
FOCUS GROUP WITH HEALTH PROFESSIONALS IN ENFIELD

Enfield Race Equality Council - Health Inequalities Focus Group – 19th July 2013

Participants

- Laura Andrews, Enfield CCG, Patient & Public Engagement Manager
- Roger Hallam, EREC, Board Member
- Paul Allen, London Borough of Enfield Commissioning Team, OD Commissioning Manager
- Michael Sprosson, LBE, Health, Housing & Adult Social Care, Commissioning Team
- Emdad Haque, North & East London Commissioning Support Unit, Equality & Diversity Manager
- Rathai Thevananth, CCG, Practice Manager Rep on CCG
- Chandra Bhatia, EREC, Chief Executive
- Yemisi Oluyede, Barnet & Chase Farm Hospital NHS Trust, Associate Director of HR Workforce, Health
- Jide Odusina, Barnet & Haringey Mental Health Trust, Head of Equalities and OD Communications
- Bridget Thorn, Enfield Carers Centre, Carers Advice/Support Worker
- Martin Garnar, LBE – Communications, Policy & Performance, Equalities Officer Communities
- Parin Bahl, HealthWatch Enfield, Board Member
- SPRC: Elena Vacchelli (FG moderator), Alessio D’Angelo, Preeti Kathrecha

Social Policy Research Centre
Middlesex University 45
Annex 1

Hospitals in Enfield

- Royal Free London NHS Foundation Trust
  (since 1 July 2014 Barnet Hospital and Chase Farm Hospital have become part of the Royal Free London NHS Foundation)
  www.royalfree.nhs.uk Tel: 020 3758 2000

- North Middlesex University Hospital NHS Trust
  www.northmid.nhs.uk Tel: 020 8887 2000

- Barnet, Enfield and Haringey Mental Health Trust
  www.beh-mht.nhs.uk Tel: 020 8702 3000

Enfield Community Trusts

ECT provides healthcare in within the community, outside of hospitals in Enfield. It includes sexual health, health visiting and nursing for long term illnesses including diabetes and heart failure

GP practices in Enfield

Enfield CCG has a membership of 54 GP practices and commission healthcare for 312,466 patients in Enfield. This group is chaired by Dr. Alpesh Patel. It has four localities with GP representatives assigned to each one.

- **North West**: Chase, Enfield Town, Cockfosters, Highlands - Dr Alpesh Patel & Dr Mike Gocman.

- **North East**: Turkey Street, Enfield Lock, Enfield Highway, Southbury, Ponders End, Jubilee - Dr Ujjal Sarkar & Dr Raj Mazumder.

- **South West**: Southgate, Grange, Winchmore Hill, Southgate Green, Palmers Green, Bowes - Dr Janet High & Dr Anshu Bhagat

- **South East**: Bush Hill Park, Hazelbury, Lower Edmonton, Edmonton Green, Upper Edmonton - Dr Parvan Sardana & Dr Fahim Chowdhury

Enfield CCG contact details

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Cockfosters Road, Barnet
EN4 0DR Tel: 020 3688 2800 Email: communications@enfieldccg.nhs.uk
Website: www.enfieldccg.nhs.uk
Annex 2

Organisations that took part in the research

**Enfield Children & Young Persons Services (ECYPS)** - provides advice and support to voluntary organisations working with children & young people aged 0-25 years.

**Enfield Saheli** - offers support and advice to Asian women in Enfield and provides many different services including advice on benefits and council services, domestic violence advocacy service, exercise classes and healthy living advice, mental health support and guidance, social and cultural activities.

**Enfield Somali Community Association (SECCA)** - support group catering for the Somali community, providing information and advice on issues such as health, housing, education, employment.

**Naree Shakti** - Asian women’s group provides an informal advisory service for Asian women who are isolated by language and cultural barriers. They also provide a number of activities, including health and social events, yoga, and an elders drop in club.

**One to One** - charity providing information, help and support to people with learning disabilities, including training opportunities, social and sport activities.

**Tamil Relief Centre (TRC)** - provides services for refugees and immigrants to enable them to Resettle and make a positive contribution to society. Empowers disadvantaged people to act on their own to meet their needs by helping them develop their skills, knowledge and attributes.