Bilingual and culturally sensitive outreach project

"Good or Bad": A response to Healthwatch by Basingstoke residents from minority communities

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"Good or Bad"

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Executive Summary

During December 2014 a total of 124 individuals from minority communities completed the Healthwatch form "*Good or Bad*". The results suggest that as people get older their attitudes harden either positively or negatively towards their experience with the healthcare system. The care ratings of those who only made positive comments, compared with those who made only negative comments, were significantly different. These results were independent of sex or GP surgery.

Respondents identified issues both of particular merit and concern in their experience with the health system. Issues of merit identified included: quality of care, the efficiency and quality of services, staff. As for issues of concern, those identified were: accessing services, communication with healthcare professionals, poor quality of clinical treatment, attitude of staff and the lack of respite care.

The biggest issue of concern was that of waiting to access GP and hospital services and there is perhaps a need for more transparency from GP surgeries about how appointments are issued. The evidence also pointed to concerns about communication and, in particular, issues of understanding between patient and health professional when involving those with limited spoken English. GP surgeries and hospitals might wish to look at communication with patients about the nature of treatments, the ways in which they work and possible side effects along with the reasons why treatments may extend over considerable time periods. There is also a serious issue of the basis of consent to treatment when involving someone with limited English language skills. The evidence also points to concerns about how the changing population is bringing different cultural expectations about how a medical service operates and how the interaction between medical practitioner and patient is undertaken. Finally, the evidence has indicated concerns about problem resolution whether with GP surgeries, hospitals or other health care providers.

Introduction

In December 2014, Hampshire Wellbeing Services CIC (HWS) was commissioned by Healthwatch Hampshire to obtain 100 responses from members of minority communities to its public form "***good or bad***" which seeks public views on health and social care services within the NHS. When received, HWS was to analyse the responses and report back to representatives of Healthwatch and the communities. This report sets out the findings of the responses to the form and forms the basis of reporting to Healthwatch and the communities.

HWS sourced responses to the Healthwatch survey form via a number of pathways:

- HWS Community Wellbeing Champions (CWC), who used their cultural connections to find respondents in their communities;
- HWS staff visiting community groups;
- HWS held open meetings for community members in community settings,
- Distribution of forms to community leaders, representatives, or spokespersons who passed them on to members for completion.

As a consequence, returns were received from the following groups:

- Migrants from Eastern Europe
- Muslim women
- Hindu Association
- Afro Caribbean community
- Popley residents of varied ethnicity
- Chinese community
- Bcot students of varied ethnicity
- Nepalese under 55
- Sikh community
- QMC Students of varied ethnicity
- Malaysie community
- Polish community
- Nepalese seniors

Responses of the participants who attended the community consultation meeting about the ***"Good and Bad"*** report can be seen in Appendix 1. Results of the analysis of the 124 "***Good and Bad***" feedback forms can be seen below.

Results

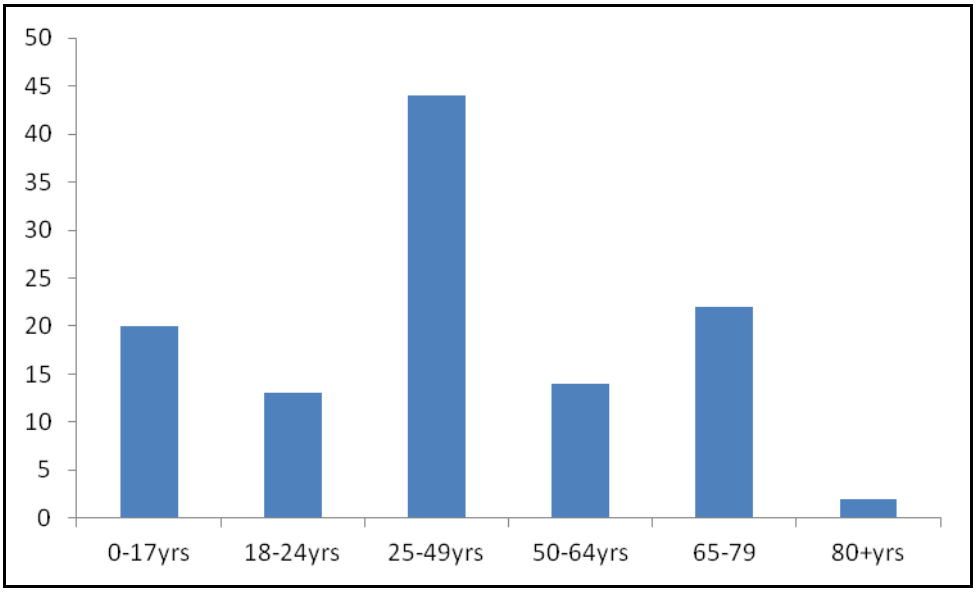
In total, 124 responses were obtained. In fact more were received after the closing date probably caused by Christmas and new-year delays.

There was some ambiguity in the form which may have affected the responses. Respondents were asked to indicate if they were reporting about themselves or someone else. Of the 124 respondents, some 35 (28.2%) indicated they were responding on behalf of someone else. However, in the question which followed "*Do you consider yourself to have a disability?*" it is not clear if the information being sought is about the person completing the form or the individual about whom the form is being completed. Thus, of the 9 individuals indicated as having a disability, 3 indicated they

were reporting about someone else. As a consequence, we cannot be certain that there has been no misunderstanding about this question (and perhaps others) given that some respondents indicated a limited English capability. We would suggest a review of the wording on the form.

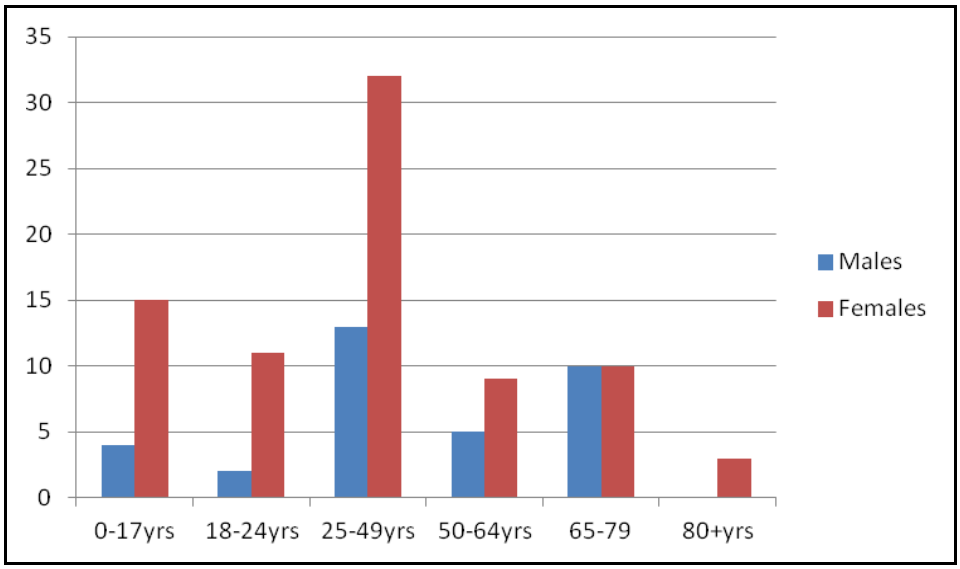
Of the 124 respondents, 83 were from women, 34 from men and 7 declined to provide an age range. The breakdown of ages was as follows:

Fig 1: Ages of all 124 respondents



When analysed by sex, the following distribution was found:

Fig 2 – All 124 respondents by male and female



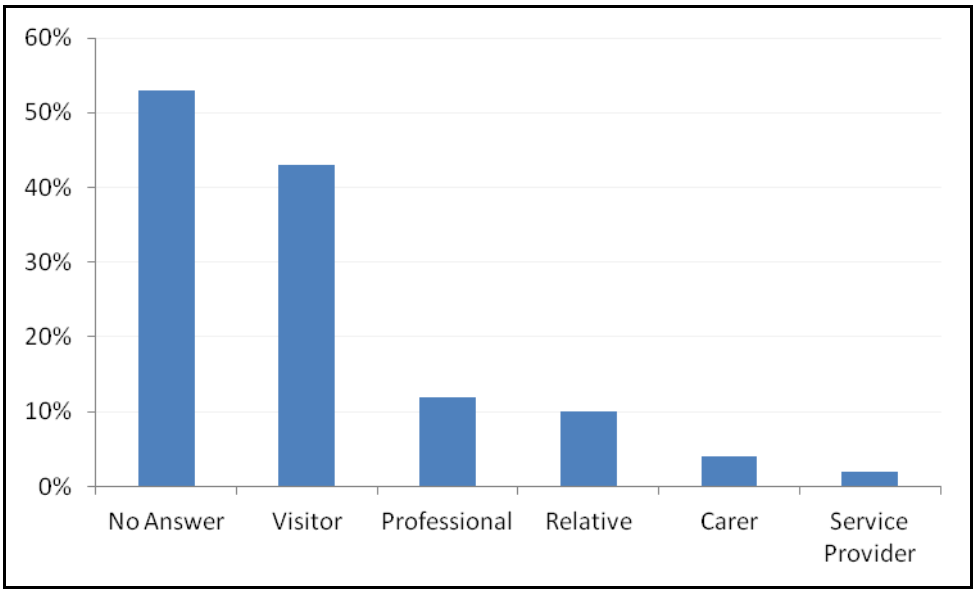
As mentioned above, there were 9 individuals who indicated they had a disability. Of these, 7 were men and 2 women. Their ages ranged as follows:

Fig 3 – Ages of respondents having a disability

Ages	0-17yrs	18-24yrs	25-49yrs	50-64yrs	65-79	80+yrs
Males	0	0	3	0	4	0
Females	0	0	0	1	0	1

The form also asked respondents to indicate what role they had. We feel this question was ambiguous with the result that more than half of respondents did not answer it. The questions also suffers the problem that a carer can also be a relative providing a service under the arrangements for delegatiion of personal budgets. What role might they then choose to include on the form? We are not sure what the term "visitor" means in respect of form completion. We suspect it has been interpreted as visting the GP or a hospital as a patient, but we feel the meaning is unclear.

Fig 4: Respondents by stated role



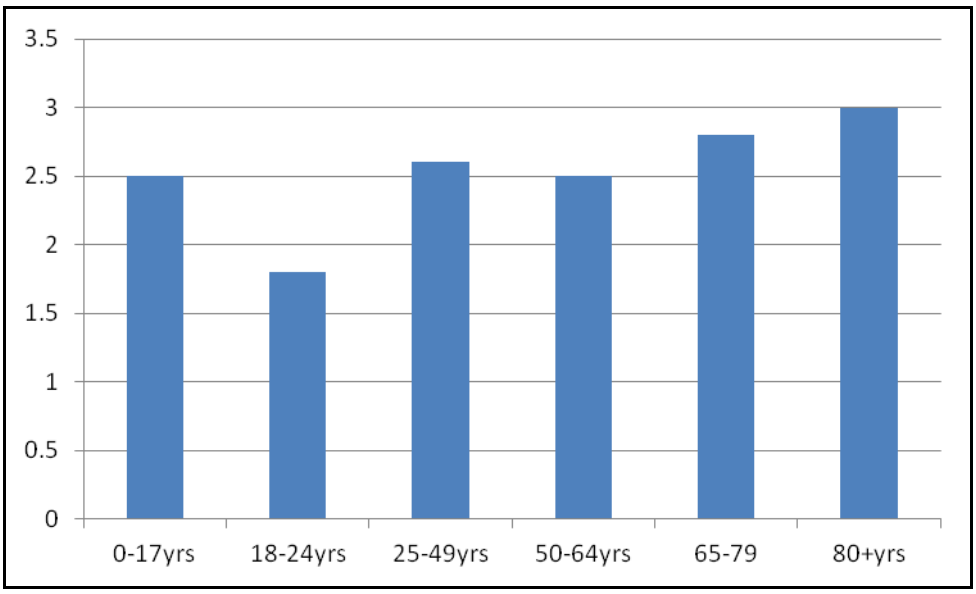
Respondents were asked to indicate what their "story" was about. When compared with the contents of the "red" description box, it became clear that what had been indicated as a category for the "story" did not always match the statements in the "red" box. Consequently, when analysing the written statements in the "red" box, we recategorised the statements taking into account what other respondents had said and meanings attached to the wide range of statements made.

All respondents were asked to rate the care received against the categories of poor, average, good and excellent. Respondent responses were scored 1 – 4 against the categories and an average score of 2.5 was generated for the whole 124 respondent population – that is halfway between average and good.

When comparing the ratings between men and women, avearge scores were 2.6 for men and 2.5 for women. Subject to the conditions above, the aveage score for those with a disability was 2.5.

When age was taken into account across all 124 respondents , there was some evidence of a rising mean with age.

Fig 5: Mean scores for care rating by age



However, when male responses were separated from those of females, the trend was less clear.

Fig 6: Mean care rating by men

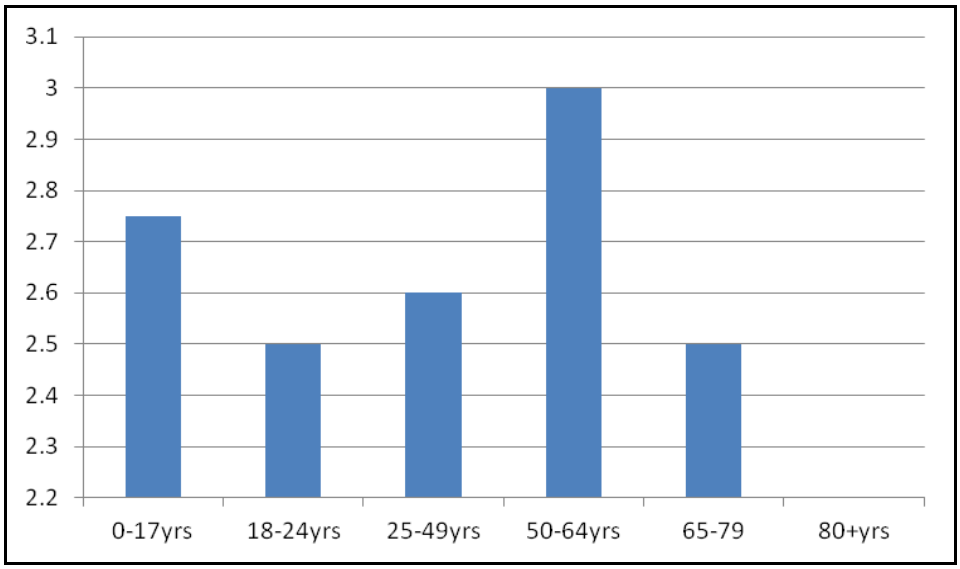
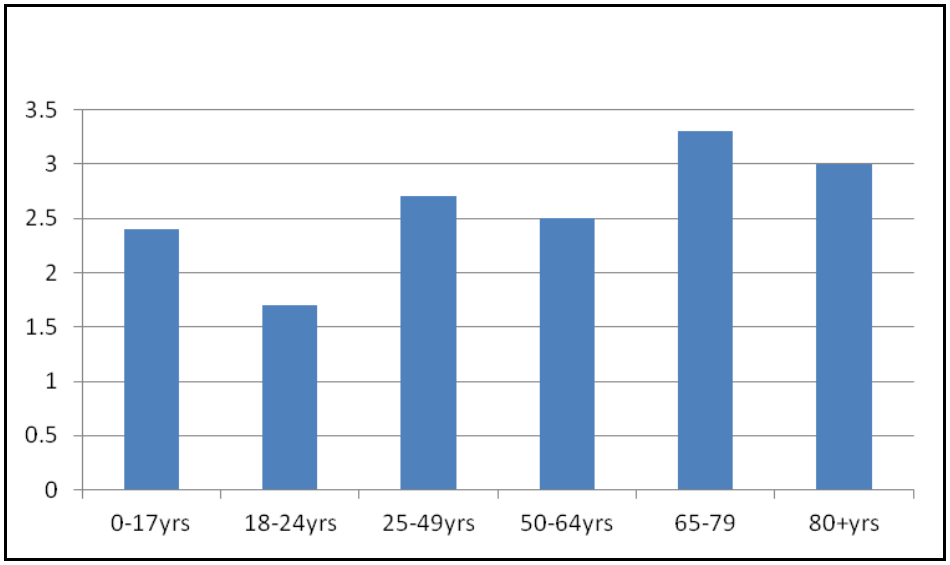


Fig 7: Mean care rating by women



As can be seen, whilst there is a suggestion of a trend for women to have a higher average care rating as they age, this is not reflected in the ratings for men.

Taking all 124 respondents, there was no statistical significance between the responses of men and women on the care rating.

When the written responses of respondents were considered it became clear there were four categories arising:

a) Those who gave no written response
b) Those who gave only positive responses
c) Those who gave only negative responses
d) Those who gave both positive and negative responses

The numbers of responses were as follows:

Fig 8: Style of responses by number and percentage

	No of Respondents	% of Respondents
Only Negative Comments	62	50.0
Only Positive Comments	31	25.0
Both Positive and Negative Comments	24	19.6
No Comments	7	5.6

A further analysis of care ratings was undertaken by focusing on those who made only positive comments or only negative comments. The consquential average care ratings were:

Fig 9: Average care ratings by type of comment

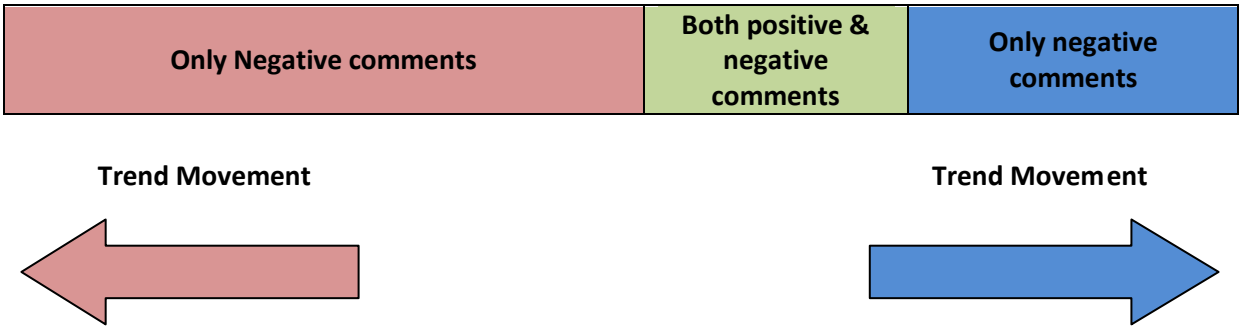
Only Positive Comments	3.1
Only Negative Comments	2.0

Thus the average care rating of those who only made positive comments, at 3.1, equated to just above "Good" on the Healthwatch form. The average care rating for those who only made negative comments was 2.0, or "Average" on the Healthwatch form.

On further analysis of the scores for each group, it was found that the two sets of ratings were statistically significant at both the 0.05 and 0.01 levels.

What this suggests is that there were two groups of people whose experiences were vastly different when in contact with health services. The experiences created different qualitative judgements about the health service which were not due to chance. The results suggest a continuum of experience with, at one end, those who have very positive experiences whilst, at the other end, those who have very negative experiences.

There appears to some kind of force impacting on the participant population which has caused it to spread along a continuum where, at one end are customers of the health service who feel they have had a poor experience whilst at the other end of the continuum are other customers who feel happy with their experiences.



What is not clear from the evidence is why this polarisation has taken place. An analysis was undertaken by age. The first interesting point is that the younger age groups have the highest proportion offering both positive and negative comments. (Fig 10) From the age of 25, some respondents previously offered both positive and negative comments appear to move into either the positive only group or the negative only group. The evidence in Fig 9 suggests that the movement is more likely to be towards positive only comments group although whilst the positive only comments group inceases in proportion after the age of 25, the proportion of each age group offering only positive comments declines thereafter.

Fig 10 indicates that in general terms, as the respondents aged, they increased their liklihood to make only negative statements and reduced their liklihood to make only positive statements.

Fig 11 seems to indicate that, in general terms, younger people were more likely to make both positive and negative comments. There also appears to be a trend in which the probability of making both positive and negative comments falls with age.

The evidence suggests that as age advances, respondents were less likely to make only positive comments and less likely to make both positive and negative comments.

Fig 10: % of age groups making only positive or negative comments

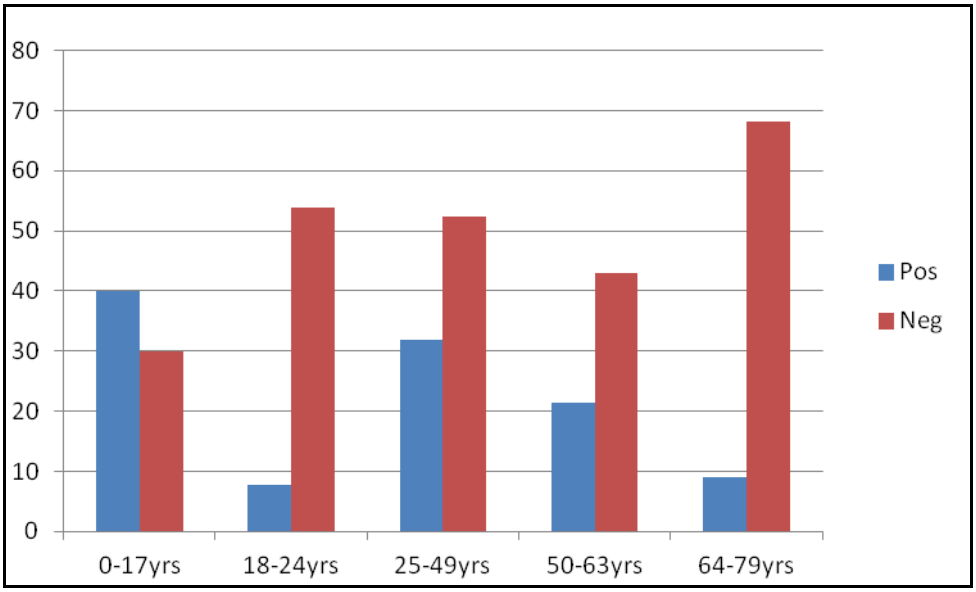
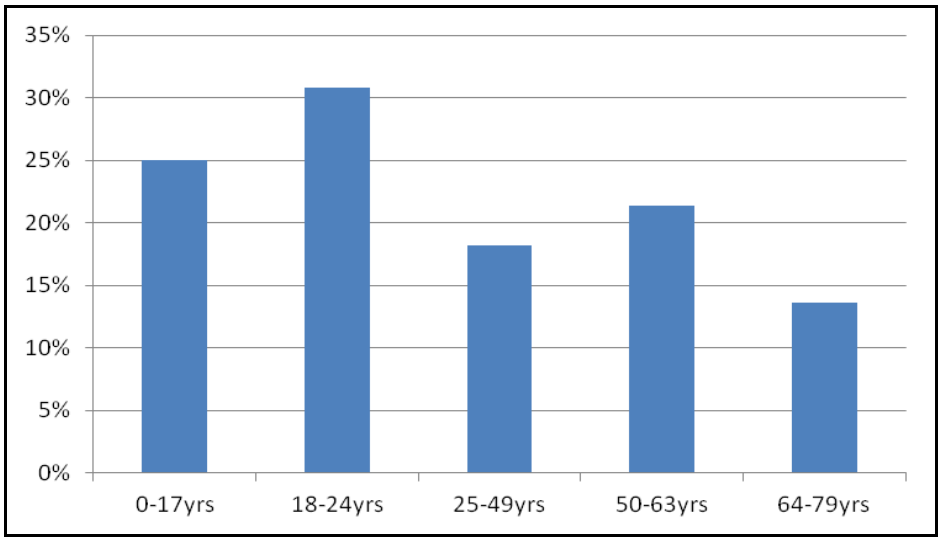


Fig 11: % of age groups making both positive and negative comments



When examining the ages of males and females who only made positive or negative comments (Figs 12 and 13), there remains a suggestion that attitudes become firmer with age but the difference between men and women is not clear. In the case of those only making positive comments the anomaly of the 18-24 age group disrupts the pattern of responses. Further work would need to undertaken to understand why, in this particular age group, so few respondents made only positive comments but appear to be found making both positive and negative comments (Fig 10). However, both Figs 12 and 13 appear to indicate that for both men and women there is a trend linked to age. As both men and women age, there appears to be a trend for those only making positive comments to reduce and for those making only negative comments to increase.

Fig 12: % of males and females making only positive comments

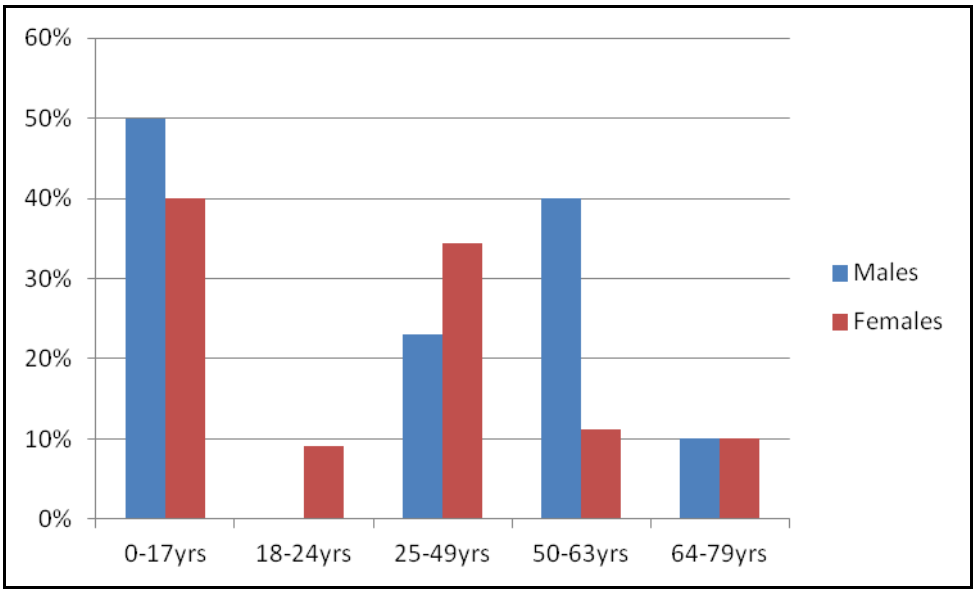
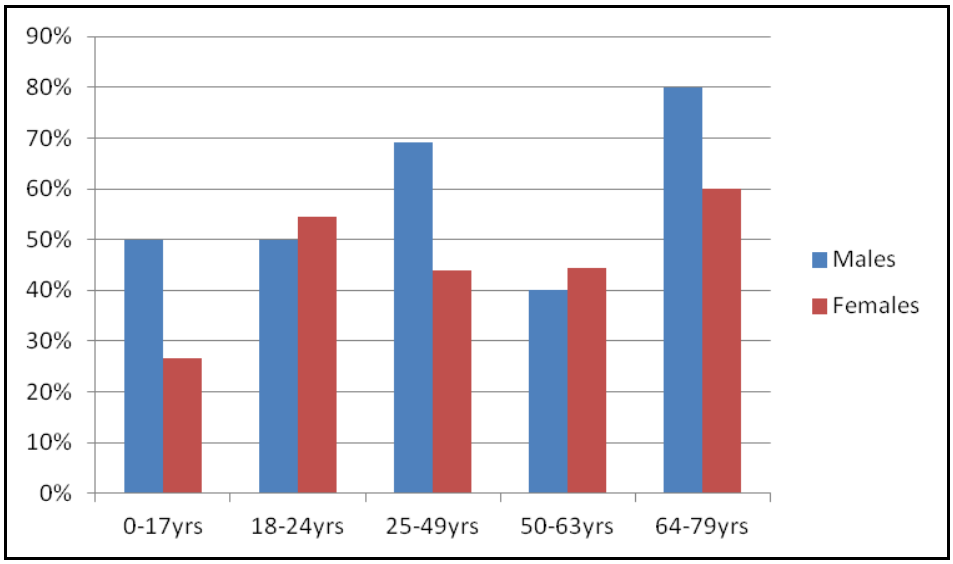


Fig 13: % of males and females making only negative comments



An analysis of the categories of response was made on the three main groups of respondents – those making only positive comments, those making only negative comments and those making both positive and negative comments.

Fig 14 sets out the categories of those making only positive comments and, of the comments made, comments supportive of clinical care attracted the highest proportion (38%) followed by the efficiency of services (29%), staff (16%), good services (16.1%) and general support (3.2%). To be placed in the category of "efficient services", respondents made comments about the timing of services provided and/or the connectivity of services. Comments placed in "good services" made no reference to time.

Fig 14: Categories of comment from those offering only positive comments - by % response

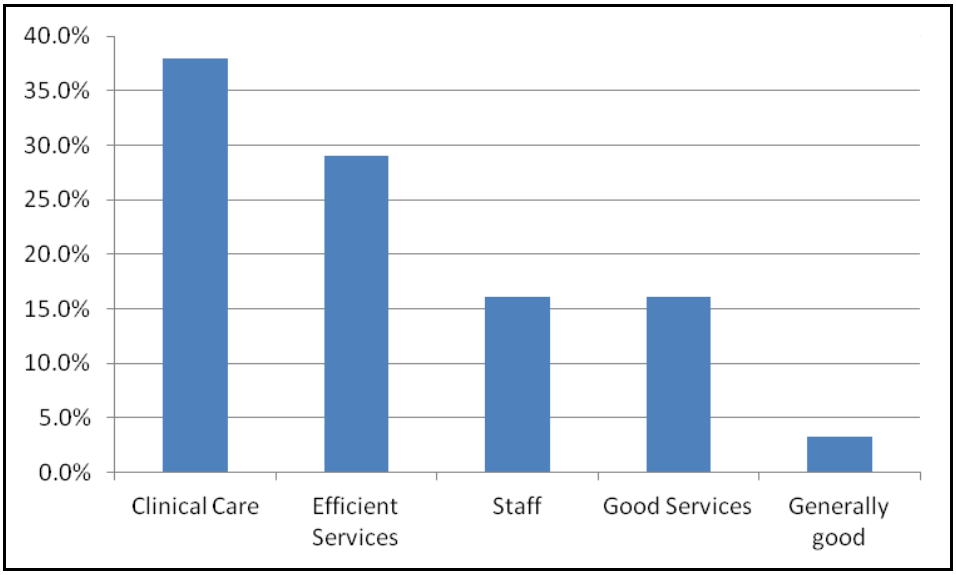
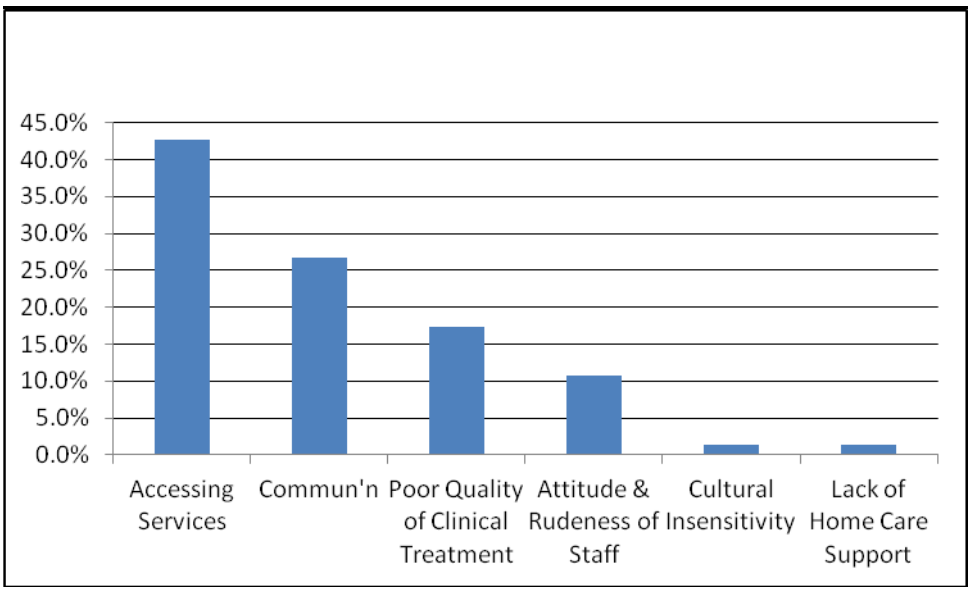


Fig 15 sets out the categories of those making only negative comments and, of the comments made, comments critical of the process accessing services attracted the highest proportion (42.7%), followed by communication issues (26.7%), the quality of clinical treatment (17.3%), rudeness and the attitude of staff (10.7%), cultural insensitivity (1.3%) and the lack of home care support (1.3%).

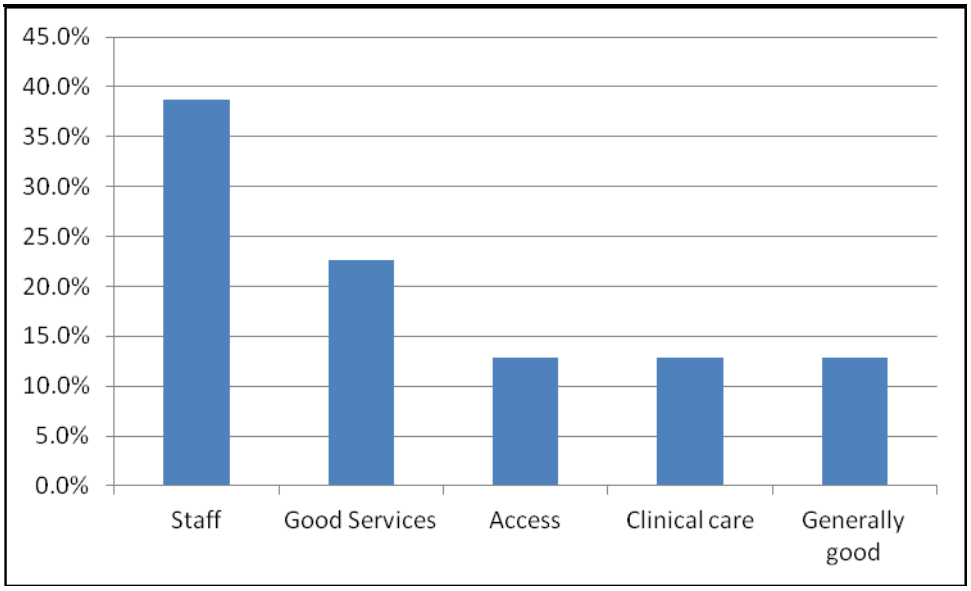
It was noticeable from the comments that, for some, use of the English language is problematic. Whilst this was particularly visible for the Nepalese community, it is likely that this is a problem found in other communities. However, this is not the only communication issue. For some respondents, seeing different doctors when visiting a GP surgery causes frustration due not only to the problems that might arise establishing communicative relations with a range of doctors, but also due to a feeling that testimony has to be repeated due to non-recording from earlier visit(s).

Fig 15: Categories of comment from those offering only negative comments - by % response



An analysis was also undertaken of the categories of response by those who made both positive and negative comments to see if there was any difference to the categories of the other two main groups. Figs 16 and 17 set out the positive and negative categories for this group. The most prominent category of positive comment was support for staff (38.7%), followed by praise for good services (22.6%), ease of access to services (12.9%), clinical care (12.9%) and general compliments (12.9%).

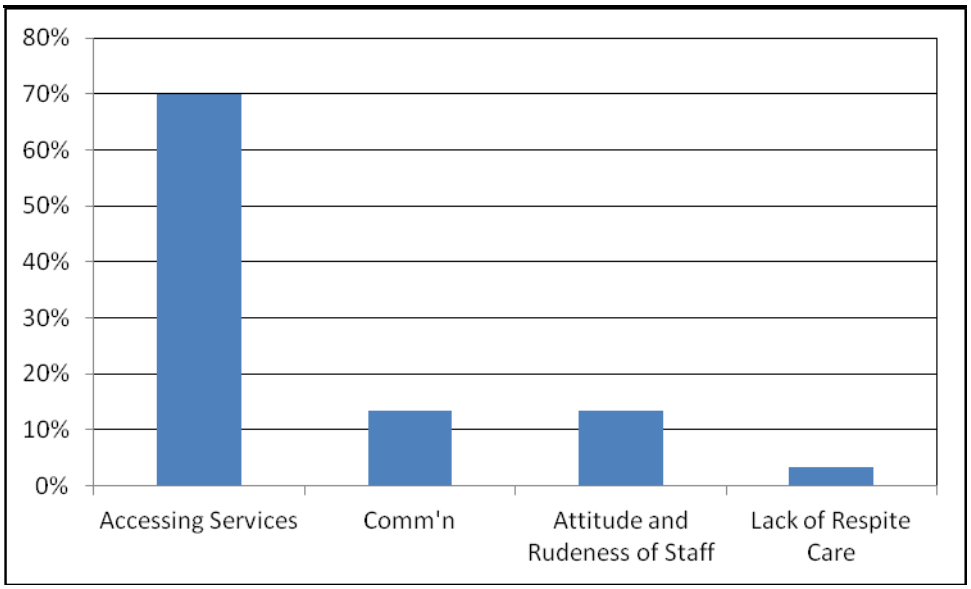
Fig 16: Categories of positive comment from the group offering both positive and negative comments - by % response



The categories of negative comment from those making both positive and negative comments are dominated by problems of accessing services (70%), followed by communication (13.3%), rudeness and attitude of staff (13.3%) and access to respite care (3.3%).

It is interesting that this group make no mention of criticisms of clinical care as does the group which only made negative comments. The balance of criticism from the group only making negative comments is also weighted more across categories, than that for the group making both positive and negative comments, where the main focus is on issues of accessing services.

Fig 17: Categories of negative comment from the group offering both positive and negative comments - by % response



Respondents provided their comments in a variety of formats ranging from a few words to lengthy submissions. It is perhaps part of the compromise in eliciting responses to the forms that the comments are made in an abbreviated form. This offers the challenge of interpreting what is written when the terminology used by patients is abbreviated and limited. What may be clear to the author may be unclear to the reader.

To help others understand the comments made, we provide below examples of positive and negative comments from the categories.

Examples of positive comments.

Good Services

- *Always found the services provided at the GP & hosp fantastic.*
- *Good GP services generally, however, hardly use service as good health generally.*
- *I feel that the local healthcare services are generally good and have not experienced any problems.*
- *I am very happy with the service which I get from my doctor and hospital.*

- *GP and hospital services are very good locally. When I or my parents have needed their services they have been understanding and supportive with empathy.*

Efficient Service

- *No problem whatsoever to see my GP as and when I want to. No complaints.*
- *Hospital - welcomed on arrival, all info accurate, pain relief straight away. Left by carers only when settled, seen by doctor every day. All assistance given straight away.*
- *Had very good experience at gynae ward. Staff very nice and welcoming, had treatment on the day of appointment. High standards of care and delivered in proper manner of time.*
- *Went to have check-up due to a swollen face. Sent to A&E, assessed straight away and transferred to Guildford hospital to see face surgeon. Assessed and operated on following morning. 3 pm on ward and spent 3 days in hospital. Medicines provided on discharge with all guidelines for rest of treatment.*
- *Always can make same day appointment. Doctor and nurse are always helpful and well knowledgeable. Very happy with the surgery and the service they provide for the local people.*

Staff

- *Excellent staff and they are doing a good job.*
- *I'm very happy with the service provided by the staff. My GP ... Makes me feel like I am in good hands.*
- *Staff were amazing, they stopped and gave their time answering questions, great care with patients, always smiling and kind.*

Clinical Care

- *Care given was superb and the consultant was very supportive.*
- *Happy with my care for my health and social care*
- *I was taken to hospital by ambulance and had a very good service. After treatment I was taken home by ambulance and later got a phone call after to see how I was doing.*
- *Local GP service and hospital service is very good and accessible. I am generally pleased with the care and support I get from my GP.*
- *The doctor has explained all the side effects of the medicine very detailed. Very satisfied.*
- *Good service and the nurse and the consultant are very professional*
- *Received good care. Service was excellent.*

Examples of negative comments.

Cultural insensitivity

- *Some faith group females prefer to be seen by females only and I don't think the medical centre understand that.*

Poor quality of clinical treatment

- *Had to send resident to hosp due to a fall. Was informed no injuries but not walking properly. Then later on that day had phone call that his hip was broken. Doctor made 2 x-rays and still wasn't sure if there was a fracture.*
- *Problem of unresolved food exclusion diet over a year after beginning treatment.*
- *The doctor who took my smear test wasn't professional enough.*

Delays in accessing services

- *Takes a long time to book appt when urgent, no late appts so always have to take time off work.*
- *My husband went into hospital on 18 September 2014 to have an epidural in his hips. That went fine, despite not going down to theatre in the afternoon instead of morning. He should*

have had a follow-up in 6 wks. He is still waiting for the appointment and it is now mid-Dec. He is in a lot of pain and discomfort.

- *I am 29 wks pregnant and a few days ago I received a tell call from my midwife to say I've got low iron level and to see the GP. However, they couldn't offer any appt before Xmas.*
- *I need my doctor to give me a time so that I can go to with my carer.*

Attitude & rudeness of staff

- *Feels like doctors never believe what you're saying.*
- *Hassles to get an appointment, staff in the reception are not polite and helpful*
- *Some Doctors have not enough patience and are not kind.*

Communication

- *I could not say what I wanted to say to my GP. If I had interpreter I could express my problem.*
- *There are language problems for me. They don't understand what I said and I don't understand what they said. If I had an interpreter I would get good service.*

Lack of home care support

- *My husband is under a care package from Hampshire Social Services and I would like more support so that I can get more respite.*

Conclusions

Any attempt to understand the experience of the local minority communities is limited by a number of factors. Firstly, is the nature of the sample and, in particular, its representation of the wider non-white British population? The respondents to this initiative have a wide age range and originate from many of the local minority communities. This is a good start. However, there are communities not represented and the age and gender mix does not reflect the broader community.

A second factor is the process of understanding the thoughts of those from minority communities, not only because an interface of non-first language is used for some, but also that the ideas and concepts of health and social care may not be the same across cultures. Such differences might impact on what is, or might be, expected of a health service and how it is judged.

A third factor is that in any such exercise it may be argued that those who have strong negative emotions may come forward to express their views and that this may skew any results. We have assumed that this might be the case and do not assume that merely because those who have offered only negative comments outnumber those who have only provided positive comments, that this is necessarily reflected in the wider community.

A fourth factor is the Healthwatch form itself. We feel the nature of the questions asked, and those not asked, limit the data about the respondent and the sharpness of consequential analysis. We feel some questions are ambiguous leading, in some instances, to the collection of relatively low quality data.

Notwithstanding these limitations, the evidence suggests a continuum of experience amongst members of minority communities. That continuum flows from those having very positive experience to those having very negative experience. The care rating scores for these two groups were found to be significantly different and we are led to conclude that some factor, or factors, other than chance has impacted on the process of experience to create the continuum.

The evidence suggests that there is a link between age and the nature of comments made. As respondents age, there is a tendency for attitudes to become hardened and more negative comments made. However, we feel more work is needed on this issue.

Recommendations

a) That Healthwatch review the questions on the form to eliminate all ambiguity, to include a question relating to ethnicity and to refine the respondent's age range.

b) That a similar exercise is conducted based on white British residents and a comparison made with the results in this exercise.

c) That an attempt is made to undertake an annual survey using a structured sample to understand the experience of the whole Basingstoke community.

d) GP surgeries should find ways of improving waiting times to acquire an appointment.

e) GP surgeries should be more transparent about the process and criteria by which appointments are allocated.

f) GP surgeries and hospitals should improve the communication with patients, in particular about the nature of treatments, the ways in which they work and possible side effects along with the reasons why treatments may extend over considerable time periods.

g) GP surgeries and dentists should find ways of communicating better with those who have little or no spoken English. This may include statement cards about major conditions and treatments in a range of major languages along with provision for a translator to be used in specific situations.

h) Medical practitioners should be provided with training to enable them to understand that those who originate from minority communities, which now constitute a large and growing proportion of the population, bring with them differing cultural expectations about how a medical service operates and how the interaction between medical practitioner and patient operates.

i) That GP surgeries have improved processes for welcoming and resolving uncertainties, difficulties and complaints that patients have about interacting with the health system.

Healthwatch - Hampshire

"Good or Bad": A response to Healthwatch by Basingstoke residents from minority communities consultation

Meetings - Notes

Thursday 29 January 2015

Meeting 1: Basingstoke Discovery Centre (12:45 - 2:15 pm)

Attended by:

Mona Roya	Irainan Community
Vincent Mudame	Society of Cameroonians in Basingstoke
Im Gurung	Nepalese community
Samina Hemmuth	Basingstoke Multicultural Forum
Dr. Ken Brown	Hampshire Wellbeing Services
Annie Noble	Hampshire Wellbeing Services

Participants' responses to the findings of the "Good or Bad" Report:

Access

"*Seeing a doctor can be particularly frustrating when the children are ill. Walk-in clinic were really good and enabled a fast diagnosis"*.

Language barriers

"*Some minority women (with limited language skills) rely on their husbands to take them to the doctor or clinics*".

"*GPs are moving towards telephone appointments but this does not help if English is an additional language or someone has poor little/no English, or a strong accent*".

"*Many people from ethnic minority communities do not feel understood by UK medical professionals. They go home (overseas) for medication and use this medicine rather than go to the doctors. Medication is cheaper back home"*.

"*Elderly people in the Nepalese community face language barriers. They need a suitable person to interpret. Currently, a family friend or children are interpreting – problems arise when these interpreters are not available".*

Cultural differences and skin tone

"*The red and flushed appearance of a white person with a fever or temperature is not reflected in a person with dark skin tone. In these circumstances, doctors need to listen more to the patient*".

Other comments
"GP sometimes refer patients to A&E"

"People who are here illegally, (overstayed a student or holiday visa) when unwell, fear visiting their GP, as they are concerned about detection. When they do go it's normally too late".
"New arrivals (to the UK) can also experience culture shock when interfacing with systems and services of the developed world".

Message to Healthwatch

The group want to see a list of actions Healthwatch will take in response to the report and the views that have come out of this meeting.

ACTIONS: HWS to:
- send copies of all participants views to both meeting attendees
- meet with Healthwatch to get responses to the issues raised by attendees
- feedback Healthwatch response to attendees

Meeting 2: Chute House (6:30 -8:00pm)

Attended by:

Lakshmi Kulkarni	Basingstoke Multicultural Forum
Richu Phillips	Malaysie community
Marcia Hamilton	Caribbean community
Simone Grant	Caribbean community
Islam Jaliata	Basingstoke and Deane – Equality Officer
Nisha Sharma	Nepalese community
Regina Gurung	Nepalese community
Prem Gurung	Nepalese community
Adrian Towers	Bracknell Forest
Steve Manley	Healthwatch- Hampshire
Dr. Ken Brown	Hampshire Wellbeing Services
Annie Noble	Hampshire Wellbeing Services

Participants' responses to the findings of the "Good or Bad" Report:

"*There is a tendency for receptionists to ask for details/information they should not be seeking*".

"*The approach of receptionist needs to change. They need to be more patient particularly when dealing with people where language may be a barrier - perhaps they could to speak slower*".

"*There is not a lot of information to inform patients about services and resources. Lack of information about the care patients were to receive or received*".

"*Many immigrants are accustomed to seeing the same doctor, who is familiar with their medical history, however in the UK they may have to wait up to a month to see the same doctor*".
"*Many migrants/overseas visitors are not aware GPs are only given 5-10 minutes per patient*".

"*UK GPs do not have the specialist skills to deal with all conditions they are presented with. If they do not have the answer they suggest tablets to encourage the patient to wait. Whereas in Nepal the doctor is in the hospital, he/she can carry out examinations, have access to additional expertise, recommend and provide treatment*".

"*Doctors give you the option of choosing a procedure even when you are not in a fit state to make such a decision*, *for example, a woman in labour*"

"*Patients would benefit from an interaction with a doctor that provided reassurance in addition to the formality of the process*".

"*The way the GP interacts with patients impacts on their attitude towards GPs in general and their willingness and process for accessing health services*".

"*Hackwood Medical Centre has a visible statement indicating that they do not provide language services. Patients who need a translator are to arrange their own. Services should be accessible to all*".

"*There are language barriers, so the Polish and Portuguese go home to get treatment as it's faster and cheaper".*

"*A Russian woman dissatisfied with the diagnosis from UK doctors took her child back to Russia to get a diagnosis. The Nepalese also go back to Nepal to get a diagnosis. A doctor should be able to*

diagnose a common illness such as gallstones in a Nepalese patient. Why does a person have to 'go home' to get a diagnosis?"

"*UK GPs are not always able to diagnose certain illnesses that are prone to ethnic minorities*".

"The procedures people are subjected to can be too complicated. They do not understand the systems".

"Some communities feel it wrong to complain about medical practitioners as they are respectful of professionals".

"Learning to be assertive about yourself and your needs is what's needed here. People need to ask questions. How do we empower senior people to stand up for themselves?"

Healthwatch response – Steve Manley

Healthwatch has relationships with the CCG, CQC and these organisations have a statutory obligation to respond to Healthwatch.

ACTIONS:

- Healthwatch will:
    - work with HWS to come up with recommendations
    - meet with HWS to discuss the report findings
    - review the 'Good and Bad' forms to include equality: ethnicity and religion
    - add the 124 completed forms to their database

HWS announced it plans to set up a new wellbeing group and invited participants to attend the first meeting on Tuesday 24 February. There will be two meetings from: 10:30am to 12 midday. Then again from 6:30 to 8:00pm.

ACTION: HWS will prepare recommendations and invite the NHS, social services and other local stakeholders.

Participants requested 3 Healthwatch surgeries at Chute House a year. Healthwatch are to consider this. Healthwatch made it known they had funding for Interpreters and for consultation for these surgeries.

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