

# ETHNICITY PROFILING IN PRIMARY CARE

The Princes Park  
Health Centre Model



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# Contents

List of Figures.....	3
List of Tables.....	4
Executive summary.....	5
<b>1. INTRODUCTION</b>	
1.1 Introduction to the report.....	7
1.2 Princes Park Health Centre.....	8
1.3 Princes Park Health Centre Team.....	10
1.4 The Service Development Team.....	10
1.5 Project Title.....	10
<b>2. AIMS AND OBJECTIVES.....</b>	<b>12</b>
<b>3. GAINING COMMITMENT</b>	
3.1 Princes Park Health Centre team.....	14
3.2 Community leaders.....	15
<b>4. DATA COLLECTION</b>	
4.1 Introduction.....	17
4.2 Collecting SDI data.....	18
4.3 Questionnaire details.....	20
4.4 An exploration of reasons for non-response.....	22
<b>5. DATA ANALYSIS</b>	
5.1 Introduction.....	24
5.2 Demographic characteristics.....	24
5.3 Health and Illness.....	33
5.4 Patient satisfaction.....	38
5.5 Lifestyle choices.....	47
<b>6. DATA INTERPRETATION</b>	
6.1 Demographic characteristics.....	50
6.2 Health and Illness.....	52
6.3 Patient satisfaction.....	54
6.4 Lifestyle choices.....	55
<b>7. USING PIF AND PIS DATA</b>	
7.1 Introduction.....	57
7.2 A strategy for coronary heart disease.....	58
7.3 Special clinic sessions.....	60
7.4 Smoking cessation.....	60
7.5 Decisions about DNAs.....	61
7.6 Other initiatives.....	62
<b>8. COMMUNITY PARTNERSHIP.....</b>	<b>64</b>
<b>9. CONCLUSIONS.....</b>	<b>66</b>
<b>10. RECOMMENDATIONS FOR ETHNICITY PROFILING</b>	
10.1 Collection information on ethnicity.....	70
10.2 Data items.....	71
10.3 Working with community leaders.....	71
10.4 Improving patient response rates.....	71
10.5 Establishing a database.....	71
10.6 Data analysis.....	72
10.7 Data use and improving the quality of health care.....	72
References.....	73

## List of Figures

1.1A	Map showing location of Princes Park Health Centre, Liverpool..	7
5.2A	Mean age of patients.....	25
5.2B	Patient population by ethnic group.....	25
5.2C (i)	Marital Status - White British patients.....	27
5.2C (ii)	Marital Status - Other Ethnic Groups.....	28
5.2D	Main spoken language.....	28
5.2E	Main language prefer to read.....	29
5.2F (i)	Housing tenure - White British patients.....	30
5.2F (ii)	Housing tenure - Other Ethnic Groups patients.....	30
5.2G	Percentage of damp housing.....	31
5.2H	Car ownership.....	31
5.3A	Self perceived health.....	34
5.3B	Patients on medication.....	35
5.4A (i)	Patients' preference - Sex of GP.....	38
5.4A (ii)	Female patients' preference - Sex of GP by ethnic group.....	39
5.4B	Time spent waiting to be seen.....	40
5.4C	Time spent waiting for an appointment.....	41
5.4D	Time spent with GP.....	42
5.4E	Satisfaction with outcome of visit.....	44
5.4F	Understanding the GP.....	45
5.4G	Availability of an interpreter.....	46
7.1A	Improving the quality of health care .....	57

## List of Tables

1.2A	Socio-economic and Ethnicity characteristics of Granby, Abercromby and Smithdown electoral wards	8
5.2A (i)	Ethnic group as a percentage of the patient population	26
5.2A (ii)	Ethnic group as a percentage of the Other Ethnic Groups combined	26
5.2B	Marital Status	27
5.2C	Main spoken language	28
5.2D	Language prefer to read	29
5.2E	Housing tenure - All patients	30
5.2F	Employment status	32
5.2G	Religion	33
5.3A (i)	Self perceived health	33
5.3A (ii)	Self perceived health (Somali and Yemeni family origin)	34
5.3B	Factors impacting on health	35
5.4A	Patients' preference - Sex of GP	38
5.4B	Patients' preference - Sex of GP by patients' ethnic group (Male)	39
5.4C	Patients' preference - Sex of GP by patients' ethnic group (Female)	39
5.4D	Patients' preference Vs. Sex of GP normally seen	39
5.4E	Ease of getting to PPHC	40
5.4F	Waiting to be seen - response "much too long"	41
5.4G	Waiting for an appointment - response "much too long"	41
5.4H	Time spent with GP	42
5.4I	Able to talk about problems	43
5.4J	Able to talk about problems by ethnic group	43
5.4K	Satisfied with the outcome of the visit to the GP	44
5.4L	Ability to understand the GP by ethnic group	45
5.4M	Ability to understand the GP Somali and Yemeni Family Origin	45
5.4N	Interpreter available when seeing GP	46
5.4O	Choice of interpreter	46
5.5A	Prevalence of having ever smoked	47
5.5B	Prevalence of present smoking	47
5.5C	Prevalence of alcohol consumption	48
7.2A (i)	History of angina	58
7.2A (ii)	History of angina (Somali and Yemeni Family Origin)	58
7.2B	History of myocardial infarction	59

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We look forward to their continued support for this initiative.

### EXECUTIVE SUMMARY

Ethnicity profiling is an essential step in assessing the health care needs of populations defined by self ascribed ethnicity or family origins. Only with this information are evaluations of the specific morbidity, mortality and health care utilisation profiles of these patient populations possible. Ethnicity profiling provides information about White British as well as Black and Minority Ethnic populations. This information can be used at all levels, with Primary Care Groups and Trusts being best placed to use it.

Establishing the ethnicity profile of GP practice patient populations requires more than an opportunistic approach to data collection. At the outset a mail out of patient forms requesting information about self ascribed ethnicity and family origins is needed. Information about ethnicity for new patients should be collected at registration and this should be a routine part of the registration process.

Additionally, ethnicity profiling should be part of a wider information gathering exercise that should include information about religion, languages spoken and read. This data collection exercise could provide the opportunity for updating patient information previously collected, such as telephone numbers and postal addresses. It could also be used to collect other items of information required for informing and improving the delivery of health care.

Of utmost importance is the need to ensure that the information collected is used to inform decisions about health care provision and delivery. This will require some competence in data analysis and interpretation as well as a desire and the mechanisms for bringing about changes to policies and practice.

Finally, ethnicity profiling will require commitment at all levels, from the Department of Health, to Health Authorities, to Primary Care Groups (Trusts) and down to individual GP practices. In addition to the improvements to the quality of patient care, GP practices must benefit directly from patient profiling. Detailed patient profiles should be used to ensure a fairer distribution of resources to individual GP practices.

# 1



**Introduction**

## INTRODUCTION

1.1 This report provides details of the achievements and the challenges faced by the Princes Park Health Centre Service Development Initiative (PPHC-SDI) which is based at Princes Park Health Centre in Liverpool (Merseyside). In Section 1 a brief account of Princes Park Health Centre and the Primary Care and Service Development Teams is presented. Section 2 sets out the aims and objectives of the initiative. Sections 3 to 8 describe the processes that were required for ethnicity profiling and some of the ways in which the data collected was used to inform decisions about health care provision. Section 9 provides conclusions and a summary of the achievements of the SDI. Section 10 presents recommendations for ethnicity profiling in primary care.

Fig 1.1A

*Map showing location of Princes Park Health Centre, Liverpool*



**Princes Park Health Centre**

## PRINCES PARK HEALTH CENTRE

1.2.1 In 1973, the All Saints Church on Bentley Road in Liverpool 8 (Merseyside) was declared redundant. It was bought by Liverpool City Council for £12,000 on the persuasion of Dr. Cyril Taylor a local General Practitioner (GP) who was then a Labour member of the City Council for the Princes Park Ward (later Granby Ward). The church was demolished and plans for the construction of a health centre on the site were started. Work on this health centre (later to be named Princes Park Health Centre) was completed in early 1977 at the cost of £171,500. On 17 March 1977 it was officially opened to the public by Sir Alec Merrison, then Chairman of the Royal Commission on the NHS.

1.2.2 In the words of Dr. Taylor it was hoped that this new health centre would not only provide "better facilities for waiting rooms, pram parks, play rooms, modern toilets, etc., but also an opportunity for many different workers involved in community care to be under one roof, meet each other every day and forge what is now known as the primary care team". He expected that in addition to providing medical care, this facility would "provide opportunities for the users to promote activities, health education and self-help groups".

1.2.3 Originally, Princes Park Health Centre accommodated two medical practices with District Nurses and Health Visitors housed within the health centre. In addition the premises provided an office for a social worker attached to the City Council, a first for Liverpool at that time. After the first two years, one practice moved to separate premises. Dr. Cyril Taylor and his partner Dr. Iwan Lewis Jones remained and took on a third partner Dr. Katy Gardner.

1.2.4 In July and August 1981, after the Toxteth riots, the health centre was visited by Dr. Gerard Vaughan (Minister of State for Health) and Mr. Michael Heseltine (Secretary of State for the Environment). These visits had considerable bearing on the approval of a grant which was awarded from the Inner City Partnership, for extending the premises and in March 1984 a seminar room (and library) and additional interviewing rooms were completed. A further grant of £215,000 was obtained from the Inner City Partnership in 1986 and this went towards building offices for Health Visitors and District Nurses. In June 1994, the then Mersey Regional Health Authority provided another grant of £410,000 and this was used to improve patient accommodation.

**Table 1.2A Socio-economic and Ethnicity characteristics of Granby, Abercromby and Smithdown electoral wards.**

	Granby	Abercromby	Smithdown	Liverpool
Unemployment rate	41.6%	33.4%	32.5%	21.6%
Housing tenure	14.9%	16.6%	30.1%	51.1%
Lone parent families	14.3%	7.9%	10.9%	7.0%
No car	81.6%	75.1%	75.2%	56.9%
B&ME population	27.7%	20.0%	7.1%	3.8%

Source: OPCS 1991 Census

*Key to Table 1.2A*

*Unemployment rate:*The number unemployed of working age as a percentage of the economically active population of working age.*Housing tenure:*The percentage of households owned by occupants.*Lone parent families:*The percentage of households with 1 adult only with children 0 to 15 years.*No car:*The percentage of households with no car.*B&ME population:*The percentage of the population not White British.

**1.2.5** Princes Park Health Centre is an inner city GP practice serving some of the most deprived communities in Liverpool. Patients reside mainly in the electoral wards of Granby, Abercromby and Smithdown (Table 1.2A) which are characterised by high levels of unemployment, homelessness, drug misuse and mental health problems. The practice also provides care to relatively large Black and Minority Ethnic (B&ME) populations, mainly Somali and Yemeni.

**1.2.6** The practice became a Primary Care Act Pilot in 1998 and is now part of the North Mersey Community NHS Trust (NMCT). The NMCT employs the General Practitioners, Community Nurses and Practice Staff with services delivered, developed and managed through a Primary Medical Care Services contract between the Liverpool Health Authority and the NMCT. It is linked with another GP practice in Liverpool, Garston under the Bridge a single handed practice which has recently moved into a purpose built community centre.

**1.2.7** Approximately 8000 patients are currently registered with the practice (January 2000) and these patients are served by a Primary Care Team which numbers 34 staff including 6 GPs (4 fulltime and 2 part time), 10 nursing staff (3 part time) and 15 administrative and reception staff. Additionally the practice liaises with other local health care teams to provide extended services such as -

- \* Local psychiatry clinic
- \* Midwifery
- \* Physiotherapy
- \* Citizens Advice Bureau
- \* Dietician
- \* Chiropody
- \* Counselling services
- \* Health visitor team working especially with children at risk
- \* Somali link worker
- \* Community Drug Worker
- \* Primary Care Deprivation Worker

**1.2.8** The practice collaborates closely with two University departments of General Practice and is an undergraduate and a postgraduate training practice for medical students and GP registrars respectively. The practice also collaborates with the Public Health departments at Liverpool John Moores University and at The University of Liverpool providing primary care exposure for students on public health degree programmes. Over the years it has been host to many innovative projects such as writers workshops and art festivals in attempts to get local people involved, and to publicise the notion of the health centre as a proactive place with an emphasis on health rather than illness.

## THE PRINCES PARK HEALTH CENTRE TEAM

### Health Visitors

Ms. Alison Jennings  
Ms. Isla Cameron  
Ms. Marylin Brown

### District Nurses

Patricia Jones  
Elizabeth Hunter  
Christina Clarke  
Joanne Sullivan  
Carol Wilson

### Practice Nurses

Veronica Mooney  
Clare Corless

### Counsellors

Mark Fisher  
Elisabeth Miur

### Consultants in Primary Care

Katy Gardner  
Lis Davidson  
Martin Smith  
Mark Burns  
Mike Eujoneatse  
George Fairburn

### Administrative and clerical

Beth Collins (Manager)  
Val Ravenscroft (Supervisor)  
Ann Johnson  
Susan Taylor  
Patricia Agalamany  
Lisa Leckey  
Julie Jones  
Irene Duffy  
Karen Hewitt  
Zoe Owens  
Julie Croucher  
Mary Huxham  
Ms. Lyndsey Jones  
Ms. Pip Abraham  
Mr. Paul Hewitt  
Ms. Marion Barr  
Ms. Val Ravenscroft

### Homeless Project Worker

Ms. Nicola Higham

## THE SERVICE DEVELOPMENT INITIATIVE STEERING GROUP AND TEAM

### Steering Group

Dr. Romesh Gupta (Mentor)  
Professor Mark A. Bellis  
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Mrs. Margaret Thompson  
Mr. Taher Ali Qassim  
Dr. Katy Gardner  
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### Project Team

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Dr. Katy Gardner  
Mr. Ben Jones  
Mr. Taher Ali Qassim  
Mrs. Faiza Alasally  
Mrs Amina Ahmed  
Mrs. Khadra Ali Mahamoud  
Mrs. Amina Hassan  
Ms. Karen Hughes (Secretarial support)

## PROJECT TITLE

1.5.1 At the very first meeting of the Project Steering Group it was decided that the term "project" would not be used in reference to the work which was to be undertaken. The view was that the term "project" had very negative connotations particularly in Liverpool 8 which had a long history of projects coming and going (when funding ceased) and doing little to improve the lives of residents.

1.5.2 It was agreed that the work that was to be undertaken was not a "project" but an initiative that had no end point. An objective protocol would be instituted to determine how effectively services offered by the Princes Park Health Centre (PPHC) were meeting the needs of the practice population (and the community), in particular patients from minority ethnic groups. This would lead to a continuous cycle of change and re-evaluation of services with practice patients, the community and the PPHC team having complete ownership of the process.

1.5.3 It was therefore agreed that the title to be used would be - "The Princes Park Health Centre Service Development Initiative" (PPHC-SDI).

# 2



**Aims &  
Objectives**

## AIMS AND OBJECTIVES

2.1 The Princes Park Health Centre Service Development Initiative could be conveniently divided into two stages. In Stage 1 the PPHC-SDI aimed to provide a strategy and the mechanism for determining morbidity and service utilisation profiles for patient groups registered with Princes Park Health Centre, defined by self ascribed ethnicity and also by family origins. In Stage 2 it aimed to use these profiles to inform and initiate action to improve access to health care services in general and in particular for Black and Minority Ethnic communities.

### **2.2 The initiative sought to achieve its aims through the following:**

1. The development of a protocol for collecting information on the self ascribed ethnicity and family origins of the practice population.
2. The standardisation and refining of the patient data system aimed at collecting health related information.
3. The linkage of computerised patient information to data collected in #1 and #2.
4. The generation of patient population morbidity and service utilisation profiles.
5. The use of patient population profiles to inform service planning and service delivery.
6. The creation of partnerships between communities and the health care team for service planning.

# 3



**Gaining  
Commitment**

## PRINCES PARK HEALTH CENTRE PRIMARY CARE TEAM

As early as 1990 there was concerted effort on the part of some members of the PPHC Primary Care Team to establish a system for recording the ethnicity of patients registered with the practice. This initiative on the ethnicity profiling of a primary care patient population was one of the first in the country and after almost eight years of considerable effort encouraging, supporting, reminding and cajoling patients and staff, information was obtained from approximately forty percent of the patient population.

**3.1.2** There was therefore considerable interest in issues related to ethnicity and health when discussions first began around classifying health need and service use by ethnic group and around developing strategies for improving access to primary care services for Black and Minority Ethnic (B&ME) communities. There was substantial experience in the difficulties associated with the collection of patient information. Added to this was an appreciation that it had been difficult in the past to find the time and / or resources (technical and otherwise) and / or commitment to use information collected during patient visits (or from surveys) to inform and direct service delivery. In spite of all this, there was still keen interest on the part of some key members of the primary care team to establish a valid and efficient system for ethnicity profiling and health related patient data collection.

**3.1.3** This level of enthusiasm however meant that the number of topics put forward as possible areas to be explored in any exercise to collect patient information were in excess of what was practical or feasible. Decisions therefore had to be made about which topics would be pursued immediately and which would be possibly addressed at a later date. It was important that this was done in a way that did not negatively affect the enthusiasm which was present. In retrospect, it would appear that in an effort to maintain this enthusiasm there was a tendency to be more optimistic than realistic about what could be achieved.

**3.1.4** At the outset however, the level of interest and enthusiasm was not homogenous. Some staff were not convinced that this initiative would or could provide any benefits for patients. Some viewed it as just another responsibility to add to the many with which they were already struggling to cope. It was necessary therefore to create as many opportunities as possible for illustrating what the benefits to patient care could be and for allaying fears about the amount of extra work the initiative would cause. This required a number of formal and informal meetings. Eventually the less convinced members of the staff began to see this initiative as something with which they could be involved. A number of reservations did however remain some were openly expressed, others did not become apparent until the later stages of the initiative.

**3.1.5** In the mean time the SDI team expended great effort to become an integral part of the health centre team. Its members made every attempt to provide as much support as possible for ongoing activities within the health centre. This support was often based on the language, computer and research skills of the individual members and these efforts had a positive impact. The SDI team came to be viewed as a resource which was competent and capable and could be relied on to provide a variety of advice and support. For the SDI team this relationship provided important benefits as well. Most importantly it gave the team an opportunity to be part of, and the sense of being able to make a significant contribution to, what could only be considered a very progressively thinking Primary Care Team.

3.2.1 Members of the SDI team met with community members and community leaders to discuss what was being proposed and to emphasise the potential benefits for individual patients and for communities in general. On all but one occasion, the response was positive as everyone viewed health issues as important and any efforts to improve access to health care as welcome. For one community leader, however, being able to categorise patients by ethnic groups did not appear to have any immediate benefits. It required several visits and many discussions to gain the support of this individual who in the end became one of the strongest supporters of the initiative.

# 4



## INTRODUCTION

4.1.1 Before discussions began with members of the PPHC Primary Care Team on ethnicity profiling and its potential for helping to improve access to health care services for B&ME communities, this health centre had already invested several years in attempting to determine the ethnic characteristics of its patient population. They had included a question on ethnicity in their patient questionnaire. This questionnaire was presented to patients at clinic visits. On completion the data were entered onto the computerised patient information system (PIS) and a hard copy placed in the patients' notes. GPs, District Nurses, Health Visitors and Practice Nurses were then asked to identify patients during consultations who had not completed these questionnaires and to encourage them to do so. After some eight years of considerable effort information on approximately 40% of the patient population had been collected in this way.

4.1.2 The proposed data collection strategy for the SDI therefore had to take into consideration the tremendous effort that had gone into the collection of the data which was available at the time. It had to recognise as well the emotional attachment to the procedures, which had been used to collect this data.

4.1.3 It would have been ideal if the SDI could have begun where the previous system had ended but this was not possible for a number of reasons.

### 4.1.3.(i) An opportunistic approach to data collection

For the SDI to continue to use only an "opportunistic" approach (waiting for patients to attend the health centre) for gathering patient information would have been inappropriate for a number of reasons.

- The additional time, which would have been required to cover a significant proportion of the remaining 60% of the patient population, would have been considerably beyond the time frame of the SDI.
- Data collected in this way from a relatively low proportion of registered patients could not be considered to be representative of the total patient population. The characteristics of patients completing questionnaires through an opportunistic approach would very likely have been different from those not captured in this way.
- Some groups of patients with the least access to the services offered at the health centre (and possibly the most unmet need) would have been the most likely to be the last to be interviewed through this approach.
- Many of the data items being collected or proposed were changeable in their nature and lengthy periods of time from data collection to data use would have had a negative impact on the validity of the data for determining present situations or planning the delivery services for the immediate or the future.

### 4.1.3.(ii) Issues of validity, reliability and comparability

The initial approach used by the PPHC for the collection of information on the ethnicity of patients had been based to some extent on the prevailing views at the time around ethnicity data collection. This approach was however not completely consistent with more recent perspectives. In particular, the ethnic classifications that had been used though innovative and clearly suited to the patient population, did not lend themselves easily to collaborative work with other health care providers either locally or nationally (comparability). The main reason for this was that they could not be easily related back to the Office of National Statistics ethnic classifications. Further, there were some parts of the questionnaire being used to collect patient information that was producing data that needed refinement to ensure the validity and reliability of patient responses.

4.1.4 The decision was therefore made to develop and use a new patient information form (PIF) for collecting patient data. This form would reflect issues covered by the previous patient questionnaire and would investigate other issues needed to clarify patient responses and allow more detailed analyses.

## COLLECTING SDI DATA

### 4.2.1 Questionnaire language.

The language of the Patient Information Form was English. Only the front cover provided a statement in languages other than English. Here the eight most common languages spoken in Liverpool (English, Arabic, Bengali, Chinese, Hindi, Panjabi, Somali and Urdu) were used to identify the PPHC as the source of the questionnaire and to provide a telephone contact number for patients wishing to receive information about it. The decision not to translate the PIF into a number of different languages was based primarily on the following.

- There was little readily available information on the ethnicity, language ability and literacy of the practice population. This information would have been essential for a language specific targeted mail out.
- There were anecdotal accounts of the inability of a significant proportion of the Somali and Arabic speaking population to read written Somali and Arabic.
- There was a clear understanding of the difficulty in maintaining the validity of responses when questionnaires are translated from one language to another.
- Support mechanisms for non-English speaking individuals had been put in place (see Section 4.2.5).

### 4.2.2 Source of questions.

Topics included in the PIF reflected issues which were targeted in the previously used questionnaire as well as additional interests of members of the PPHC Primary Care Team. The questions which addressed these topics were either constructed anew by the SDI team or designed to be consistent with approaches taken in the Office of National Statistics census questionnaire, the Health and Lifestyle Survey of England (HEA 1994) and the Fourth National Survey of Ethnic Minorities (Nazroo 1997).

### 4.2.3 Piloting of the PIF.

Before being utilised, the PIF was piloted with a purposive sample of patients. The issues addressed in this pilot included respondents' views on the clarity, appropriateness and sensitivity of questions, the time required for completing the form and the willingness of patients to comply with this request for information. This pilot provided useful information for improving the likelihood of obtaining valid responses from the questionnaire.

### 4.2.4 PIF mail outs.

A mailing list of all patients 16 years and over was generated from the computerised patient records on the "Meditel" system (PIS). A copy of the PIF and a self-addressed postage paid envelope was sent to each of these patients. A second PIF together with a reminder letter was sent out to all non-respondents if no reply was obtained two weeks after the mail out of the first.

### 4.2.5 Information help line.

A telephone help line operated by English, Arabic and Somali speakers provided information about the reasons why the PPHC Primary Care Team considered it important that patients complete the PIF. Arabic and Somali were identified from anecdotal evidence, as the key languages needed. The Arabic and Somali

speakers were at the time employed as link-workers with the NMCT and both had a good understanding of the Somali and Yemeni communities served by the PPHC. In some instances, the PIF was administered over the telephone. One version had been adapted specifically for this purpose and the SDI team members assigned to dealing with telephone calls had received additional training in telephone interviewing.

**4.2.6** Other activities aimed at improving the initial response rate.

**4.2.6 (i)** Posters announcing the mail out of the PIF were distributed in public places throughout Liverpool 8.

**4.2.6 (ii)** Announcements were made in places of worship and religious leaders were asked to encourage their faithful to complete and return the PIFs.

**4.2.6 (iii)** District Nurses, Health Visitors and General Practitioners were asked, when making home visits, to encourage patients to complete and return the PIFs.

**4.2.6 (iv)** Community leaders were asked to encourage community members with whom they had contact to complete and return the PIFs.

**4.2.7** Dealing with non-respondents.

A number of strategies (including those in 4.2.6) were used to target patients who had not responded to the initial PIF mail outs. These included an opportunistic approach when patients attended the health centre, telephone calls to those for whom telephone numbers were available, home visits, visits to community groups and special community functions and a third mail out.

**4.2.7 (i)** All patients attending the health centre were asked whether they had completed the PIF which was sent to them in the post. If they had not they were presented with another copy and encouraged and helped to complete it while they waited to be seen.

**4.2.7 (ii)** Two community members, (both female) one Somali and the other Yemeni, were employed by the SDI to contact Somali and Yemeni non-respondents. Initially, they attempted to do this first by telephone. When non-respondents could be contacted in this way they were told about the reasons for the PIF and were encouraged to complete and return it at their earliest convenience.

**4.2.7 (iii)** When telephone numbers were not available or when the telephone numbers which were listed were incorrect, the two community workers visited the registered addresses of non-respondents. If a non-respondent could be located they again provided information about the reasons for the PIF. In this instance they encouraged the non-respondent to complete the PIF while they waited. To ensure confidentiality the non-respondent was asked to seal the completed questionnaire in an envelope which was provided and to place it in the post at their earliest convenience.

**4.2.7 (iv)** The SDI staff approached community groups and community leaders within Liverpool 8 to gain their support in encouraging patients to complete the PIF. Information about the initiative was provided and any uncertainties were addressed. Meetings were arranged in both formal and informal settings. The two day Somali health and exercise programme organised during the Summer of 1999 was one example of an informal setting used for this purpose. This programme was the result of collaborative efforts on the part of the SDI, the Liverpool Health Authority, the Merseyside Health Promotion Unit and the Liverpool City Council Leisure Services. Members of the SDI team also attended Yemeni weddings and other social gatherings to inform people about the SDI.

4.2.7 (v) The final attempt at proactively reaching non-respondents was a third mail out. In this mail out a shortened version of the PIF was used. It was accompanied by another letter explaining that two previous attempts at contact had been unsuccessful and that it was feared that the patients' personal records were not up to date. Patients receiving this letter were asked to contact the health centre to confirm their addresses and telephone numbers. This opportunity was used by the SDI staff to once again encourage non-respondents to complete the questionnaire.

## QUESTIONNAIRE DETAILS STRUCTURE AND RATIONALE

### 4.3 Questionnaire details - structure and rationale.

4.3.1 As discussed in section 4.2.2 a number of questions included in the PIF reflected ones which had been used in well established national surveys. Others had been developed specifically for this initiative. Questions were arranged in sections with each pursuing a specific topic area. The following explores the rationale for the inclusion and the structure of each of these sections.

4.3.2 Personal details (Questions 1.1 to 1.6). This section provided information which could be used as unique identifiers for patients. It was expected that these unique identifiers would be provided by family and other names verified by dates of births and addresses. This section would also provide a means of checking the spelling and the order of patients' names (in particular for those patients from minority ethnic communities). Additionally, this section aimed to confirm and update postal addresses and contact telephone numbers.

4.3.3 Patient satisfaction (Questions 2.1 to 2.15). This section covered topics related to patients' access to and satisfaction with the services provided at PPHC. It explored GP gender preferences, physical access to the PPHC, waiting times, length of consultations, communication within consultations and interpreter services. It aimed to provide a baseline from which improvements in service delivery could be gauged as well as further insight into problems around access and communication that were already known to exist.

4.3.4 Health and Ill Health (Questions 3.1 to 3.18). This section explored patients perceptions about their own health, doctor diagnosed ill health and family histories of ill health. It aimed to establish morbidity profiles for individual patients and their families and for specific groups within the patient population. It focused on the conditions which the PPHC Primary Care Team considered most important - hypertension, stroke, angina and myocardial infarction, diabetes, asthma, arthritis, depression and mental illness.

4.3.5 Ethnic classification (Questions 4.1 to 4.8). A composite approach was taken for determining ethnic classification. This approach was informed, to a large extent, by the evidence and the understanding coming out of the 4th National Survey of Ethnic Minorities (Modood et al., 1997). It was based on the view

- that ethnicity as a sociological enquiry rather than a demographic definition (Modood et al., 1997) had to be considered as an identity which people use to distinguish themselves from others and not as a category imposed on them by others (Mason 1990).
- that individuals' conception of their own ethnicity was important from both

- a sociological and an epidemiological point of view.
- that ethnicity defined in this way (a sociological enquiry) was not fixed but fluid in time and in circumstance and as a consequence less suitable for some epidemiological investigations.
- that a less fluid classification of ethnicity was also required, one which would in addition be less prone to the difficulties experienced with classifications used for the 1991 census, the Health and Lifestyles Survey (HEA 1994) and the 4th National Survey of Ethnic Minorities.
- that whatever classification was used that it would allow regional and national comparisons to be made.

To satisfy these criteria a number of questions were therefore included in the PIF. Questions 4.1 and 4.2 were based on the question asked in the Office of Population Censuses and Surveys (OPCS) 1991 census and these questions sought to establish the individual's own view of his or her ethnicity. These questions were followed by questions (questions 4.3 to 4.8) which explored the individual's country of birth and his / her mother's and father's country of birth. The objective was to provide a classification based on family origins (Modood et al., 1997) not dissimilar but more incisive than that used in the 4th National Survey of Ethnic Minorities.

**4.3.6 Socio-economic status (Questions 5.1 to 5.9).** This section explored indirect measures of socio-economic status - home ownership, availability of central heating, overcrowding in households and car ownership. It aimed to provide the basis for establishing and evaluating the effect of low socio-economic status on ill health in the practice population.

**4.3.7 Language and literacy (Questions 6.1 to 6.6).** This section dealt with patients' ability to speak and read English. It also addressed main languages spoken and read. It aimed primarily to provide information on the need for interpretation and translation services.

**4.3.8 Personal details II (Questions 7.1 to 7.5).** This section explored an assortment of issues including religion, marital status and employment status. The rationale for including a question on religion in the questionnaire was based on the following. Firstly, there is a clear understanding that religious affiliation / beliefs / practices have an important impact on health and well being (Scrambler 1991). Secondly, researchers in the field of health and ethnicity have been proposing for some time that the religious dimension should be recognised more explicitly (Modood et al., 1997) and that population-based analyses exploring religion should be possible. Thirdly, this growing interest in the effect of religious affiliation / beliefs / practices on health has encouraged the Office of National Statistics to include a question on religion in the 2001 Census. Finally, the ability to provide data on this religious dimension at a practice population level was considered important for the strategic planning of both preventive and curative services and for ensuring that religious beliefs and practices were taken into consideration in the delivery of care for individual patients. Questions about employment status, marital status and other relationships sought to explore the effect of these variables on health, lifestyles and access to services. In addition it was expected that these questions would provide information about family resources and support for individual patients.

**4.3.9 Lifestyle choices (Questions 8.1 to 8.10).** This section examined past and present smoking habits, passive smoking and alcohol consumption. It aimed to provide information on the prevalence of smoking among population groups and to identify individuals and groups for whom excessive alcohol consumption could adversely affect their health.

**4.3.10** Social Security benefits (Question 9.1). This section enquired about benefits and allowances which were being received. It aimed to identify individuals who were not claiming benefits for which they were entitled.

## **AN EXPLORATION OF THE REASONS FOR NON-RESPONSE.**

**4.4.1** After the final mail out there was still approximately 25% of patients who had not completed Public Information Forms. This response rate of 75% although very high for a postal questionnaire was considerably lower than had been expected. The anticipation of a better response was based on the view that patients would have responded more positively to requests for information from their doctors. Knowing why patients did not return their completed forms was therefore considered to be important for determining the potential of future mail outs.

**4.4.2** In order to explore the reasons patients had for not responding, the SDI team visited all non-respondents whose family names began with the letter A - one hundred and sixty one (161) in total, as a purposive sample of non-responders. Of these only 31 (19%) either said that they had forgotten to return the PIF or that they had not thought it important to have done so. For another 31 patients (19%), there were no replies at the addresses given after three visits (the first during the day, the second during the evening and the third on a Sunday). For 18 patients (11%), their registered addresses were unoccupied, sometimes derelict, buildings. For 63 patients (39%), they were not known at the addresses given or had moved away some time ago. Three patients had not completed the PIF because of literacy problems, one had changed GP practice and two had died. Twelve had returned their PIFs by the time they were visited.

**4.4.3** For this group of non-respondents the predominant reasons for non-response were clearly not objections about the PIF, literacy problems or lethargy. It was based on the inaccuracy of the information available on the number of patients still registered with the practice or their present addresses.

**4.4.4** Patients who had taken the time to complete the PIF and to return it were not statistically different with respect to age and sex, from patients who had not returned PIF because they had forgotten or not thought it important ( $p = 0.21$  and  $p = 0.35$  respectively).

# 5



**Data Analysis-**  
**Patient**  
**Information**  
**Form**

## INTRODUCTION

The following represents the first series of analyses that were carried out on the data collected using the patient information form (PIF). Further and more detailed analyses are ongoing.

Analyses relate to data for 4581 patients, 16 years and over, registered with the Princes Park Health Centre. It is estimated that based on the review of non-respondents (Section 4.4) that this potentially represents over 90% of the actual patient population in this age range.

The definitions of terms, based on ethnicity and family origin, which are used to describe groups of patients in these analyses, are as follows.

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White British	Patients who identified themselves as White British in Question 4.1 of the patient information form. "To which ethnic group do you consider you belong."
Other Ethnic Groups combined	Patients who identified themselves as belonging to an ethnic group other than White British in Question 4.1 of the patient information form. "To which ethnic group do you consider you belong."
Somali Family Origin	Patients who identified themselves or their mothers or fathers as being born in Somalia.
Yemeni Family Origin	Patients who identified themselves or their mothers or fathers as being born in Yemen.

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The ways in which the results of these analyses were used to inform decisions about the organisation and delivery of health care or other initiatives with which PPHC was in partnership are presented in Section 7 of this report.

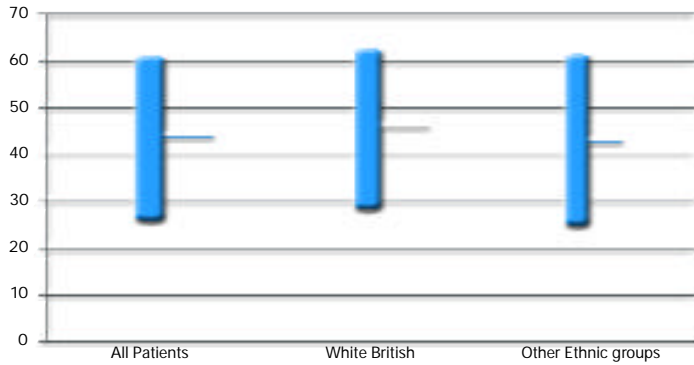
## DEMOGRAPHIC CHARACTERISTICS

### 5.2.1 Age and sex

The mean age of all patients 16 years and over was 44.6 years (S.D. = 17.25 years). For White British patients it was 45.6 years (SD = 16.83 years) and for the Other Ethnic Groups combined it was 43.0 years (SD = 17.79 years) (Figure 5.2A). This difference in the mean age of White British patients and the mean age of patients from the Other Ethnic Groups combined was statistically significant ( $p < 0.0001$ ). Forty two percent (42%) of patients were male and fifty eight percent were female (58%).

Fig 5.2A

Mean age of patients 16 years and over ( $\pm$  1 Standard Deviation)

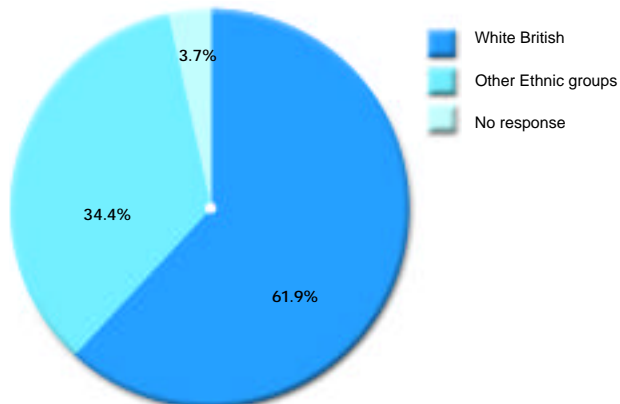


### 5.2.2 Ethnicity (self defined) and Family Origins

White British patients accounted for 61.9 % of patients, 16 years and over. Patients from the Other Ethnic Groups accounted for 34.4%. For 3.7% of patients, there was no response to the question on ethnic identity (Figure 5.2B).

Fig 5.2B

*Patient Population by Ethnic Groups*



Patients who considered themselves to be Black British (10.1%) or to belong to some Other (10.2%) ethnic group which had not been listed were the largest groups among the Other Ethnic Groups.

**Table 5.2A (i) - Ethnic group as a percentage of the patient population**

Ethnic Group	Percent of patient population	Ethnic Group	Percent of patient population
Bangladeshi	0.7	Indian	0.6
Black African	5.9	Irish	2.3
Black British	10.1	Pakistani	0.6
Black Caribbean	2.0	White British	61.9
Black Other	0.8	No response	3.7
Chinese	1.5	Other	10.2

**Table 5.2A (ii) - Ethnic group as a percentage of the Other Ethnic Groups combined**

Ethnic Group	Percentage of Other Ethnic Group
Bangladeshi	1.9
Black African	15.4
Black British	26.4
Black Caribbean	5.2
Black Other	2.2
Chinese	3.9
Indian	1.5
Irish	5.9
Pakistani	1.5
Other	26.5
No response	9.6

Among patients who identified themselves as belonging to an Other ethnic group which was not listed, Arabic (19.1%), Yemeni (16.9%), Mixed (7.7%) and Somali (7.2%) were the most common ethnic identities to which these patients subsequently ascribed themselves.

Eighty eight percent (88%) of patients who considered themselves to be Black British were born in Britain. Approximately one quarter of the fathers of these Black British patients was either born in Britain (26.7%) or in the West Indies (23.9%). Almost three-quarters of their mothers were born in Britain (74.7%). The majority of patients who considered themselves to be Black African were born in Somalia (63.5%). The other most common countries of birth for Black African patients were Nigeria (9.1%) and Britain (8.7%). Patients who were born in Somalia or whose fathers or mothers had been born there accounted for 5.1% of all patients 16 years and over. The majority of patients who considered themselves to be Arabic were born in Yemen (66.2%). Patients who were born in Yemen or whose fathers or mothers had been born there accounted for 2.7% of all patients 16 years and over.

Among patients 16 to 25 years of age, White British accounted for less than half of patients in this age group (49.6%). The next largest groups were Black British (16.1%), Other ethnic group (14.4%) and Black Africans (9.5%).

### 5.2.3 Marital status

Approximately one quarter of all patients, 16 years and over (26%), were married (Table 5.2B). White British patients were less likely to be married than patients of Somali (48%) and Yemeni (77%) Family Origin or the Other Ethnic Groups combined (32%) ( $p < 0.0001$ ). These differences in the percentages of patients who were married remained statistically significant after standardisation for age. White British patients (12%) were however more likely to be living with a partner which was relatively uncommon among patients of Somali (1.0%) and Yemeni (2.9%) Family Origin ( $p < 0.0001$ ).

**Table 5.2B - Marital Status**

	White British	Somali Family Origin	Yemeni Family Origin	Other Ethnic Groups	All patients
Married	22.6%	48.4%	76.7%	32.1%	26.2%
Single	44.2%	31.8%	12.6%	43.2%	43.8%
Living with partner	12.0%	1.0%	2.9%	6.6%	9.9%
Widowed	6.9%	10.4%	3.9%	6.6%	6.8%
Divorced or Separated - living with partner	2.2%	1.6%	0.0%	1.6%	2.0%
Divorced or Separated - not living with partner	12.2%	6.8%	3.9%	9.8%	11.3%
	100.0%	100.0%	100.0%	100.0%	100.0%

**Fig 5.2C(i)**

**Marital Status - White British patients**

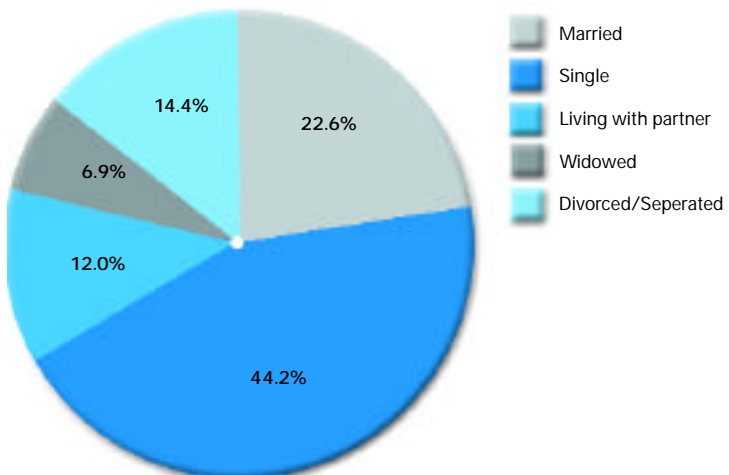
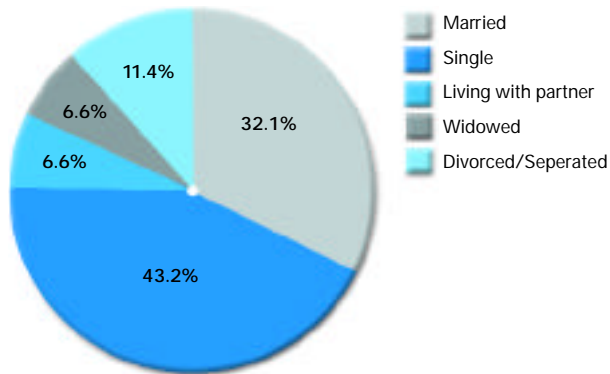


Fig 5.2C(ii)

**Marital Status - Other Ethnic Groups**

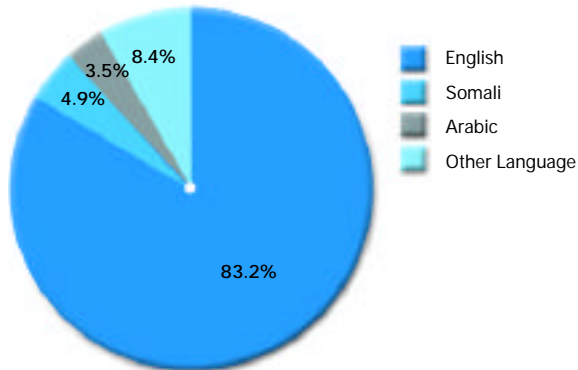


**5.2.4 Language and literacy**

Eighty three percent of patients (83.2%) reported that their main spoken language was English (Fig 5.2D) . Somali and Arabic (4.9% and 3.5%) were the next most common first languages. The first language of 39.6% of patients from the Other Ethnic Groups combined was a language other than English. About a quarter of patients (24%) whose first language was not English, responded that they spoke English very well. Another quarter (23%) considered that they spoke English fairly well.

Fig 5.2D

**Main Spoken Language**

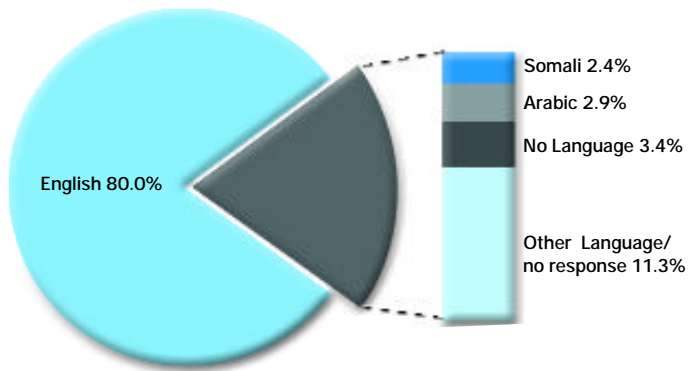


**Table 5.2C - Main spoken language**

Language	Percentage of patient population	Language	Percentage of patient population
Arabic	3.5	Mandarin	0.1
Bengali	0.5	Punjabi	0.2
Cantonese	0.4	Somali	4.9
English	83.2	Swahili	0.2
Gujerati	0.1	Yoruba	0.1
Hausa	0.1	No response	3.9
Ibo	0.1	Other	2.5

Fig 5.2E

**Main Language prefer to Read**



Eighty percent (80%) of patients said that the language that they preferred to read was English (Fig 5.2E). Arabic (2.9%) and Somali (2.4%) were the next most preferred languages. A significant number of patients (3.4%) reported that they did not read any language and these included White British patients who constituted 43.5% of this number.

**Table 5.2D - Language prefer to read**

Language	Percentage of patient population	Language	Percentage of patient population
Arabic	2.9	Somali	2.4
Bengali	0.5	Swahili	0.1
Chinese	0.7	Urdu	0.1
English	80.0	None	3.4
Gujerati	0.0	Other	1.2
Hindi	0.0	No response	8.5
Ibo	0.1		

Forty percent (40%) of patients who chose another language (other than English) as their first choice for reading reported that they read either only a little English or none at all. Forty seven percent (47%) of patients who identified Somali as their first spoken language also reported that Somali was the language they preferred to read. Twenty seven percent (27%) of these patients identified English as the language they preferred to read and a further 18% stated that they did not read any language. Twenty percent (20%) of patients who identified Somali as the language they preferred to read reported that they only read this language "a little". Seventy percent (70%) of patients who identified Arabic as their first spoken language also reported that Arabic was the language they preferred to read. Of these patients 19% reported that they read Arabic only a little.

## 5.2.5 Socio-economic characteristics

### 5.2.5(i) Housing tenure.

Twenty nine percent of patients (29.2%) were living in households that were owner occupied, either owned outright or on mortgage. White British patients (33.1%) were more likely to be living in owner occupied properties than patients from the Other Ethnic Groups combined (22.6%) ( $p < 0.0001$ ) (Fig 5.2F). Most patients (37.5%) were renting from a Housing Association.

Fig 5.2F(i)

#### *Housing Tenure - White British patients*

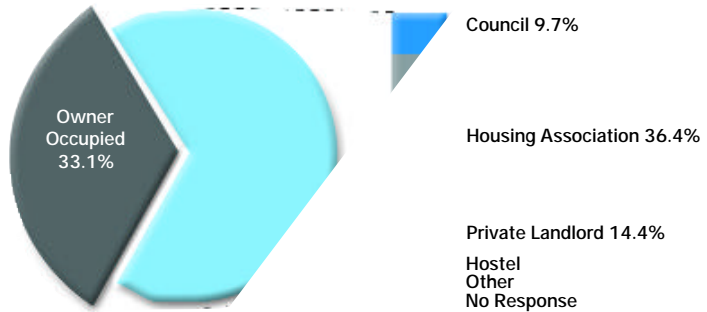
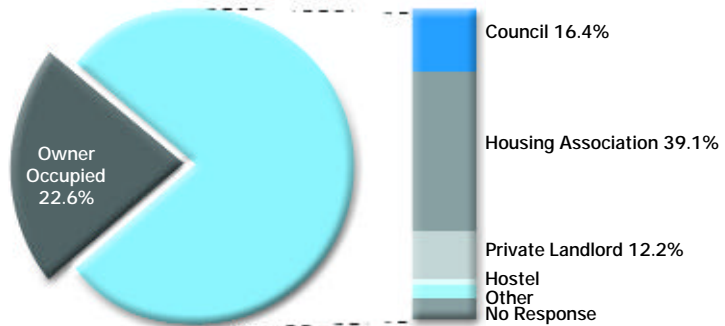


Fig 5.2F(ii)

#### *Housing Tenure - Other Ethnic Groups patients*



**Table 5.2 E - Housing tenure - All patients**

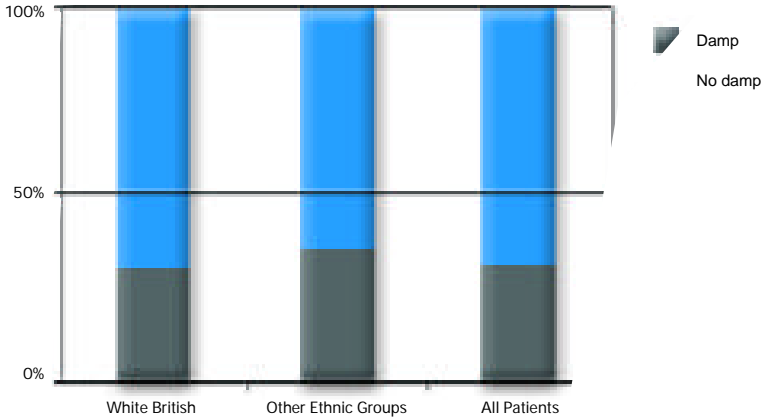
Housing Tenure	Percentage of patients
Owned outright	12.1
Mortgaged	17.1
Rented Council	12.2
Rented from Housing Association	37.5
Rented private	13.3
Hostel	1.9
Other	3.0
No response	3.0

### 5.2.5(ii) Damp housing

Thirty one percent (31%) of patients reported having damp patches on the walls of their home. White British patients (30%) were less likely to do so than patients from the Other Ethnic Groups combined (35%) ( $p < 0.0001$ ).

Fig 5.2G

#### Percentage of Damp Housing



### 5.2.5(iii) Owns a car or has use of one.

Forty six percent (46%) of patients reported that they either owned a car or had access to one. White British patients (49%) were more likely to do so than patients from the Other Ethnic Groups combined (41%) ( $p < 0.0001$ ) (Fig 5.2H).

Fig 5.2H

#### Car Ownership



### 5.2.5(iv) Employment status.

Eighteen percent of patients (18%) reported that they were unemployed at the time of interview (15% for more than six months and 3% for less than six months) (Table 5.2F). White British patients (17%) were less likely to report that they were unemployed as compared to patients from the Other Ethnic Groups combined (20%) ( $p < 0.001$ ).

**Table 5.2 F - Employment status**

	Other Ethnic Groups	White British	All patients
Employed > 30 hours	15.4%	24.8%	21.2%
Employed < 30 hours	5.8%	6.8%	6.4%
Self employed - full time	2.5%	2.5%	2.5%
Self employed - part time	1.1%	2.2%	1.8%
Retired with occupational pension	4.7%	4.9%	4.9%
Retired on private income	1.0%	0.4%	0.7%
Retired on state benefits	10.4%	10.5%	10.4%
Unemployed < 6 months	4.3%	2.7%	3.3%
Unemployed > 6 months	16.1%	13.9%	14.7%
At school	2.6%	0.8%	1.5%
Other full time education	6.8%	3.2%	4.6%
On Government training scheme.	0.7%	0.6%	0.6%
Sick < 6 months	1.3%	0.4%	1.4%
Sick > 6 months	13.2%	16.9%	15.5%
Looking after home or family	10.8%	6.9%	8.4%
Other	3.3%	1.5%	2.2%
Total	100.0%	100.0%	100.0%

### 5.2.6 Religion

One quarter of patients (25.1%) reported that they belonged to the Church of England, 22.3% that they were Roman Catholic (Table 5.2G). Twenty four per cent (24.0%) reported that they had no religion. White British patients (30.4%) were more likely to report that they had no religion than patients from the Other Ethnic Groups combined (13.7%) ( $p < 0.0001$ ). The main religion among patients from the Other Ethnic Groups was Islam (32.3%).

**Table 5.2 G - Religion**

	Other Ethnic Groups	White British	All patients
Baptist	1.3%	0.6%	0.9%
Buddhist	1.3%	1.2%	1.2%
Church of England	18.0%	29.5%	25.1%
Hinduism	1.1%	0.1%	0.5%
Islam	32.3%	0.6%	12.7%
Jehovah's Witness	0.4%	0.4%	0.4%
Jewish	0.1%	0.8%	0.5%
Methodist	1.3%	1.5%	1.4%
Pentecostal	1.0%	0.5%	0.7%
Presbyterian	0.2%	0.7%	0.5%
Rastafarian	0.4%	0.1%	0.2%
Roman Catholic	17.9%	25.0%	22.3%
Seventh Day Adventist	0.3%	0.0%	0.1%
Sikhism	0.6%	0.0%	0.2%
No response	6.3%	2.7%	4.1%
None	13.7%	30.4%	24.0%
Other	3.8%	5.8%	5.0%
	100.0%	100.0%	100.0%

**5.3****HEALTH AND ILLNESS****5.3.1 Self perceived health.**

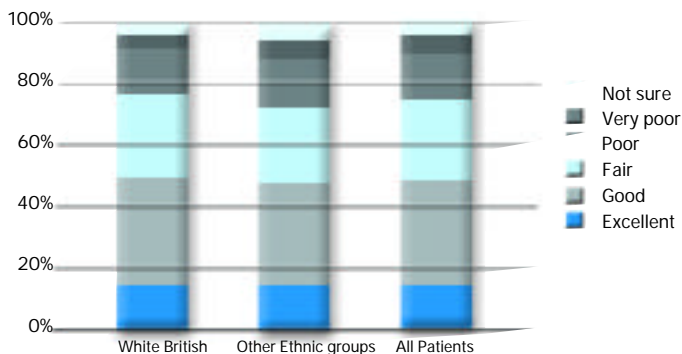
Almost half (48.5%) of all patients considered their health to be excellent or good compared to other people of their own age (Table 5.3A(i)). About a quarter (26.4%) considered their health to be fair. Twenty percent (20.7%) considered their health to be poor or very poor. White British patients were more likely to consider their health excellent or good and less likely to consider their health poor or very poor as compared to the Other Ethnic Groups combined ( $p = 0.007$ ,  $p = 0.017$ ). These differences in self perceived health remained statistically significant after standardisation for age but became non-significant after adjustment for socio-economic status (using housing tenure as a proxy measure for socio-economic status) (adjusted odds ratio = 1.08, 95% confidence intervals 0.95 to 1.23).

**Table 5.3A (i) Self perceived health**

Response	White British	Other Ethnic Groups	All patients
Excellent	13.8%	14.4%	14.0%
Good	35.6%	32.8%	34.5%
Fair	27.1%	25.3%	26.4%
Poor	15.0%	15.2%	15.1%
Very Poor	5.0%	6.7%	5.6%
Not Sure	3.5%	5.6%	4.3%

Fig 5.3A

**Self perceived health**



However, when family origin is considered, patients of Yemeni Family Origin considered their health to be better ( $p = 0.025$ ) while patients of Somali Family Origin did not have views about their health which were statistically different from that of the other ethnic groups (including White British) ( $p = 0.177$ ) (Table 5.3A(ii)).

**Table 5.3A (ii) Self perceived health**

Response	Somali Family Origin	Yemeni Family Origin
Excellent	16.1%	21.5%
Good	31.3%	36.2%
Fair	21.8%	22.1%
Poor	19.4%	10.4%
Very Poor	7.6%	7.4%
Not Sure	3.8%	2.5%

**5.3.2 Factors impacting most on health.**

"Worries at home" was the factor that was most often identified by patients (9.8%) as having the worst effect on their health (at the time of interview) (Table 5.3B). Their weight (8.1%) and their smoking (8.0%) were considered the next most important. For patients who were unemployed however the factor considered having the worst effect on their health was unemployment (20.1%). Factors considered by White British patients to have an important negative effect on their health did not vary considerably from the views of patients from the Other Ethnic Groups combined. However, White British patients were more likely than patients from the Other Ethnic Groups to consider "Worries at work" and "Exercise" as the factor impacting most on their health ( $p < 0.0001$ ). Patients from the Other Ethnic Groups were more likely than White British patients to consider "Housing" as the factor impacting most on their health ( $p < 0.0001$ ).

**5.3.3 On medication**

At the time of interview more than half of patients (56.2%) were using some type of medication (Fig5.3B). White British patients (59.1%) were more likely to be on medication than patients from the Other Ethnic Groups combined

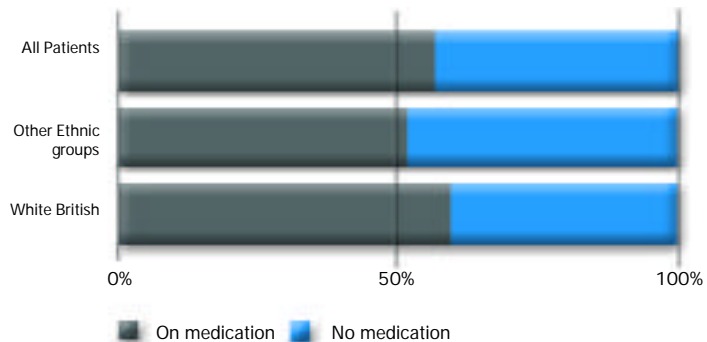
(51.3%) ( $p < 0.0001$ ). This difference remained statistically significant after adjustment for age, sex and socio-economic status (with housing tenure as a proxy measure for socio-economic status) (adjusted odds ratio 1.33, 95% confidence interval 1.15 to 1.55). However, the situation was reversed when the prevalence of present medication use was explored among patients 45 years and over. For this group of patients, 70.3% of White British patients were on some type of medication as compared to 74.1% of patients from the Other Ethnic Groups combined ( $p = 0.006$ ). For patients of Somali Family Origin (45 years and over) the prevalence of present medication use was 70.4% and for patients of Yemeni Family Origin it was 80.1%.

**Table 5.3B** Factors impacting on health

	White British	Other Ethnic Groups	All patients
Worries at home	10.9%	8.1%	9.8%
Weight	8.2%	7.8%	8.1%
Smoking	8.5%	7.1%	8.0%
Pollution in general	7.0%	7.7%	7.3%
Worries at work	8.6%	4.7%	7.1%
Living on own	5.5%	6.4%	5.9%
Exercise	7.0%	4.3%	5.9%
Being unemployed	4.6%	6.8%	5.4%
Housing	3.7%	7.1%	5.0%
Food	2.7%	2.0%	2.5%
Alcohol	2.7%	1.9%	2.4%
Crime	2.1%	2.4%	2.3%
Pollution where you live	1.4%	2.2%	1.7%
Road traffic	1.3%	1.9%	1.5%
Racism	0.1%	1.0%	0.4%
Sexual behavior	0.4%	0.3%	0.4%
Other	15.5%	12.8%	14.5%
No response	9.7%	15.4%	11.9%

**Fig 5.3B**

*Patients on medication*



### 5.3.4 Doctor diagnosed ill health

#### 5.3.4(i). Hypertension

The prevalence of self reported hypertension in patients, 16 years and over, was 17.9%. There was no statistically significant difference in the prevalence for White British patients, for patients from the Other Ethnic Groups combined or for patients of Somali or Yemeni Family Origin ( $p = 0.640$ ). Age was the only statistically significant predictor of hypertension with older age groups having increased likelihood of having reported a history of hypertension.

#### 5.3.4(ii). Stroke

Twelve percent (12%) of patients, 65 years and over, reported having had a stroke. There was no statistically significant difference in the prevalence for White British patients as compared to the Other Ethnic Groups combined ( $p = 0.105$ ). Age was the only statistically significant predictor of stroke with older age groups having increased likelihood of having reported a history of stroke.

#### 5.3.4(iii). Angina

Thirteen percent (12.4%) of patients, forty years and over, reported to have angina. White British patients in this age group (10.1%) were much less likely to do so as compared to patients from the Other Ethnic Groups combined (16.8%) ( $p < 0.0001$ ). This difference in self reported angina remained statistically significant after adjusting for age, sex, having ever smoked and socio-economic status (with housing tenure as a proxy measure for socio-economic status) (adjusted odds ratio 1.60, 95% confidence interval 1.18 to 2.17). Patients of Somali or Yemeni Family Origin however reported considerably higher prevalence than all other groups - 30% and 28% respectively ( $p < 0.0001$ ).

#### 5.3.4(iv). Diabetes

Approximately seven percent (6.9%) of patients, forty years and over, reported that they were diabetic. White British patients in this age group (5.0%) were much less likely to do so as compared to patients from the Other Ethnic Groups combined (10.5%) ( $p < 0.0001$ ). This difference in self reported diabetes remained statistically significant after adjusting for age, sex, and socio-economic status (with housing tenure as a proxy measure for socio-economic status) (adjusted odds ratio 2.17, 95% confidence interval 1.50 to 3.13). Patients of Yemeni Family Origin reported a considerably higher prevalence (23%) ( $p < 0.0001$ ).

#### 5.3.4(v) Myocardial infarction

Approximately six percent (5.8%) of patients, forty years and over, reported having had a heart attack. There was no statistically significant difference in the responses of White British patients (5.3%) and patients from the Other Ethnic Groups combined (6.6%) ( $p = 0.218$ ). Age, sex and having ever smoked were the only statistically significant predictors of a self reported history of having had a myocardial infarction. Patients of Yemeni Family Origin reported a considerably higher prevalence of heart attacks (12%) ( $p = 0.013$ ).

#### 5.3.4(vi) Asthma

Approximately nineteen percent (18.2%) of patients, sixteen years and over, reported that they had at some time suffered from asthma. There was no statistically significant difference in the responses of White British patients (17.9%) and patients from the Other Ethnic Groups combined (18.5%) ( $p = 0.479$ ). Patients of Somali and Yemeni Family Origin reported similar prevalence of asthma (17.1% and 13.1% respectively). Damp housing was not an independent predictor of self reported asthma but socio-economic status was (with housing tenure as a proxy measure for socio-economic status) (adjusted odds ratio 1.25, 95% confidence interval 1.03 to 1.53).

#### 5.3.4(vii) Depression

Approximately sixteen percent (15.8%) of patients, sixteen years and over, reported that they were always or most times sad, miserable or depressed. There was no statistically significant difference in the responses of White British patients (15.4%) and patients from the Other Ethnic Groups combined (16.9%) ( $p = 0.387$ ). Patients of Somali and Yemeni Family Origin reported a prevalence of 14.3% and 19.8% respectively. Patients who were married (8.8%), living with a partner (12.7%) or divorced / separated and living with a partner (13.1%) were less likely than patients who were widowed (16.4%), single (18.9%) or divorced/separated and not living with a partner (22.7%) to report that they were always or most times sad, miserable or depressed ( $p < 0.0001$ ).

#### 5.3.4(viii) Severe arthritis or rheumatism

Approximately half of all patients (50.9%), 65 years and over, reported a history of severe arthritis or rheumatism. White British patients in this age group (47.2%) were much less likely to do so as compared to patients from the Other Ethnic Groups combined (59.1%) ( $p < 0.0001$ ). Patients of Somali and Yemeni Family Origin reported a considerably higher prevalence (61.3% and 60.2% respectively) ( $p < 0.0001$ ).

### 5.3.5 Family history of ill health

#### 5.3.5(i) Family history of stroke

Approximately one quarter (26%) of patients reported to have had some one in their family who had suffered a stroke. White British patients (30%) were more likely to report this family history as compared to patients from all the Other Ethnic Groups combined (19%) ( $p < 0.0001$ ).

#### 5.3.5(ii) Family history of angina

Approximately one third (33%) of patients reported to have had some one in their family who had suffered from angina. White British patients (38%) were more likely to report this family history as compared to patients from all the Other Ethnic Groups combined (25%) ( $p < 0.0001$ ).

#### 5.3.5(iii) Family history of diabetes

Approximately one quarter (25%) of patients reported to have had some one in their family who had suffered from diabetes. White British patients (29%) were more likely to report this family history as compared to patients from all the Other Ethnic Groups combined (23%) ( $p < 0.0001$ ).

#### 5.3.5(iv) Family history of heart attack

Approximately one third (30%) of patients reported to have had someone in their family who had suffered from a heart attack. White British patients (36%) were more likely to report this family history as compared to patients from all the Other Ethnic Groups combined (20%) ( $p < 0.0001$ ).

#### 5.3.5(v) Family history of asthma

Forty five percent (45%) of patients reported to have had some one in their family who had suffered from asthma.

#### 5.3.5(vi) Family history of hypertension

Forty two percent (42%) of patients reported to have had some one in their family who had suffered from hypertension.

#### 5.3.5(vii) Family history of mental illness

Nineteen percent (19%) of patients reported to have had some one in their family who had suffered from a mental illness. White British patients (21%) were more likely to report this family history as compared to patients from all the Other Ethnic Groups combined (16%) ( $p < 0.0001$ ).

### 5.4.1 GP preference

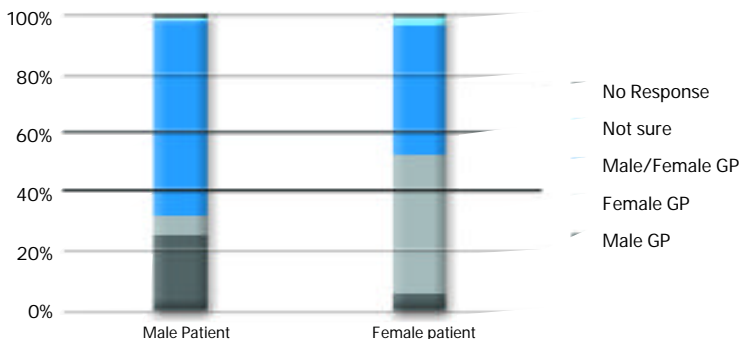
More than half (52.3%) of all patients 16 years and over, reported that the sex of their GP did not matter. For those who had a preference, 63.1% (29.9% of all patients 16 years and over) preferred a female GP. Less than a third of these patients (30.1%, 14.3% of all patients 16 years and over) preferred a male GP. More than one quarter of male patients (26.2%) preferred to be seen by a male GP and almost half of female patients (47.0%) preferred to be seen by a female GP. Male patients were significantly more likely to respond that it did not matter whether they saw a male or female GP ( $p < 0.0001$ ) (Table 5.4A).

**Table 5.4A** Patients' Preference - Sex of GP

Preference	Percentage of all patients	Percentage of Male patients	Percentage Female patients
Male GP	14.3	26.1	5.8
Female GP	29.9	5.8	47.0
Does not matter	52.3	65.3	43.0
Not sure	2.2	1.4	2.9
No response	1.3	1.4	1.3

Fig 5.4A()

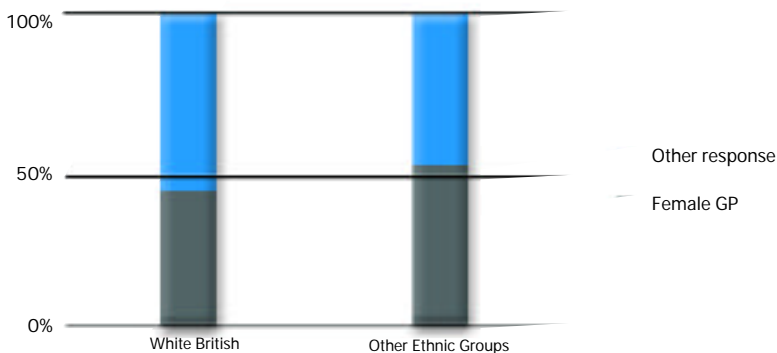
*Patients' preference - Sex of GP*



White British male patients (23.7%) were less likely to prefer seeing a male GP as compared to male patients from the Other Ethnic Groups combined (29.8%) ( $p = 0.005$ ). There was no statistically significant difference between these two groups of male patients (White British 6.0% and Other Ethnic Groups 5.6%) with respect to a preference for seeing a female GP ( $p = 0.761$ ). Female patients from the Other Ethnic Groups combined (51.9%) were significantly more likely to have a preference for seeing a female GP than White British female patients (44.1%) ( $p < 0.0001$ ). There was no statistically significant difference between these two groups of female patients (White British 5.9% and Other Ethnic Groups 5.8%) with respect to a preference for seeing a male GP ( $p = 0.988$ ).

Fig 5.4A(ii)

*Female Patients' Preference - Sex of GP by Ethnic Group*



**Table 5.4B Patients' preference - Sex of GP by Patients' ethnic group (Male)**

Preference	Percentage of White British Male patients	Percentage of Other Ethnic Groups Male patients
Male GP	23.7	29.8
Female GP	6.0	5.6

**Table 5.4C Patients' preference - Sex of GP by Patients' ethnic group (Female)**

Preference	Percentage of White British Female patients	Percentage of Other Ethnic Groups Female patients
Male GP	5.8	5.9
Female GP	44.1	51.9

Most patients who reported that they preferred to see a male GP (95.1%) also reported that they normally saw a male GP. Approximately one quarter (24.2%) of patients who reported that they preferred to see a female GP also reported that the GP they normally saw was male (Table 5.4D).

**Table 5.4D Patients' preference vs. Sex of GP normally seen**

	Prefer male GP	Prefer female GP	Does not matter	Not sure	No response
Normally see male GP	95.1%	24.2%	76.3%	54.2%	63.2%
Normally see female GP	4.9%	75.8%	23.7%	45.8%	36.8%
	100.0%	100.0%	100.0%	100.0%	100.0%

### 5.4.2 Physical access to PPHC

Over eighty percent of patients found it either very or fairly easy to get to the health centre (Table 5.4E). Those who found it fairly difficult or difficult accounted for 8.3% of patients. The most common reason for having difficulty getting to PPHC was "difficulty in walking" (47.2%). There was no statistically significant difference in percentages of White British patients (8.6%) and patients from the Other Ethnic Groups combined (7.9%) who found it fairly or very difficult to attend the health centre ( $p = 0.422$ ).

Table 5.4E Ease of getting to PPHC

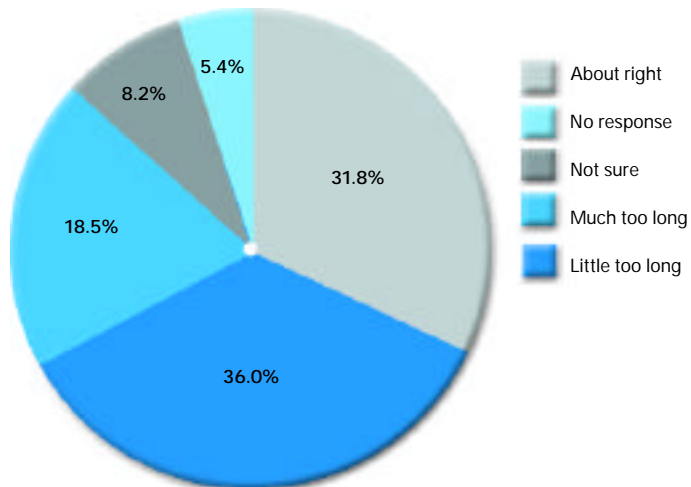
Response	Percentage of patients
Very easy	55.9
Fairly easy	28.5
Not easy or difficult	6.1
Fairly difficult	5.0
Very difficult	3.3
Not sure	0.6
No response	0.6
Total	100.0

### 5.4.3 Time spent waiting to be seen

Patients who thought they had to wait much too long to be seen accounted for 18.5% of all patients (Fig 5.4B). Female patients (22.6%) were more likely than male patients (12.3%) to respond in this way (Table 5.4F). Female patients (22.6%) were more likely than male patients (12.3%) to respond in this way. Similarly, patients from the Other Ethnic Groups (23.6%) were more likely than White British patients (15.2%) to respond that they had to wait much too long to be seen ( $p < 0.0001$ ). Age was the other statistically significant predictor of reporting to wait much too long to be seen with younger patients being more likely to do so ( $p < 0.0001$ ).

Fig 5.4B

*Time spent waiting to be seen*



**Table 5.4F** Waiting to be seen - response "much too long".

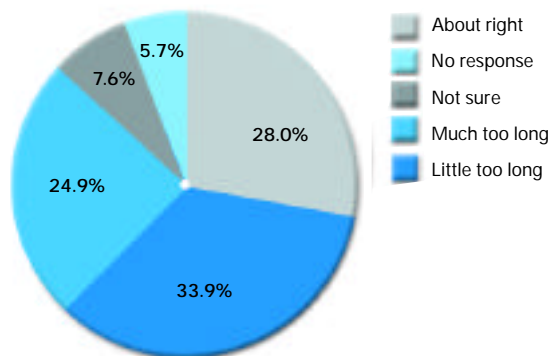
Group	Percentage of group
All patients	18.5
Female patients	22.6
Male patients	12.3
White British patients	15.2
Other Ethnic Groups	23.6

#### 5.4.4 Time spent waiting for an appointment

About one quarter (24.9%) of patients thought they had to wait much too long to get an appointment (Fig 5.4C). Female patients (27.8%) were more likely than male patients (20.8%) to respond in this way ( $p < 0.0001$ ) (Table 5.4G). Similarly, patients from the Other Ethnic Groups (26.9%) were more likely than White British patients (23.6%) to respond that they had to wait much too long for an appointment ( $p = 0.018$ ). Age was the other statistically significant predictor of reporting to wait much too long for an appointment with younger patients being more likely to do so ( $p < 0.0001$ ).

**Fig 5.4C**

*Time spent waiting for an appointment*



**Table 5.4G** Waiting for an appointment - response "much too long".

Group	Percentage of group
All patients	24.9
Female patients	27.8
Male patients	20.8
White British patients	23.6
Other Ethnic Groups	26.9

#### 5.4.5 Time spent with GP

Almost three-quarters of all patients (73.7%) felt that the time they spent with their GP was always or most of the time long enough. Patients who responded that this time was rarely or never long enough accounted for 5.3% of all patients (Fig 5.4D).

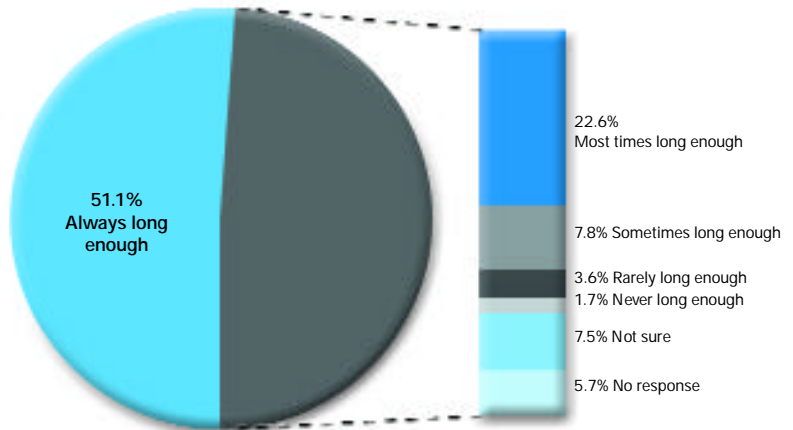
There was no statistically significant difference in the percentage of male (5.2%) and female patients (5.4%) giving this response ( $p = 0.769$ ). White British patients (3.6%) were less likely to respond that the time spent with the GP was rarely or never long enough as compared to patients from the Other Ethnic Groups combined (7.9%) ( $p < 0.0001$ ). Almost half of these patients from the Other Ethnic Groups (47.0%) had a language other than English as their first language. Age was the other statistically significant predictor of reporting that the time spent with the GP was rarely or never long enough with younger patients being more likely to do so ( $p < 0.0001$ ).

**Table 5.4H** Time spent with GP.

Response	Percentage of patients
Always long enough	51.1
Mostly long enough	22.6
Sometimes long enough	7.8
Rarely long enough	3.6
Never long enough	1.7
Not sure	7.5
No response	5.7

**Fig 5.4D**

*Time spent with GP*



#### 5.4.6 Able to talk about the problems you want to talk about.

Over three-quarters of patients (79.5%) responded that they were always or most of the time able to talk about the problems they wanted to talk about when they visited their GP (Table 5.4I).

**Table 5.4I** Able to talk about problems.

Response	Percentage of all patients
Always	56.4
Most times	23.1
Sometimes	10.2
Rarely	2.4
Never	1.3
No response	6.6

Patients from the Other Ethnic Groups combined (5.8%) were more likely to report that they were rarely or never able to talk about the things they wanted to talk about with their GP as compared to White British patients (2.8%) ( $p < 0.0001$ ) (Table 5.4J).

**Table 5.4J** Able to talk about problems by ethnic group.

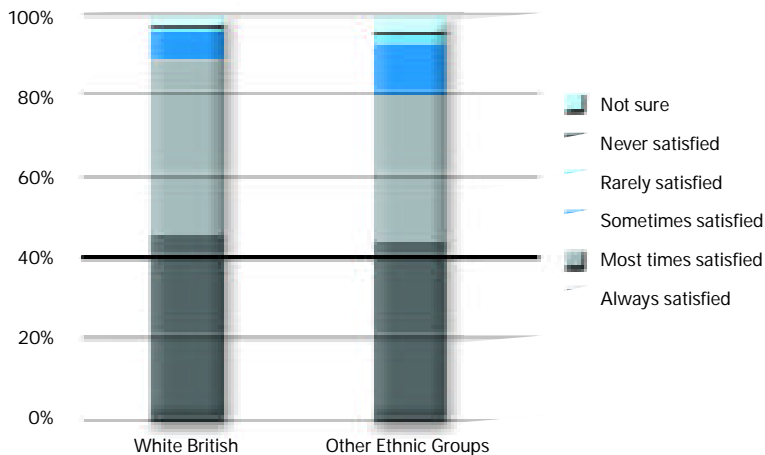
Response	Percentage of patients from Other Ethnic Groups	Percentage of White British Patients
Always	57.4	62.2
Most times	22.1	26.4
Sometimes	14.7	8.6
Rarely	3.6	2.0
Never	2.2	0.8

#### 5.4.7 Satisfaction with the outcome of visit to the GP.

Most patients (85.5%) were either always or most of the time satisfied with the outcome of their visit to the GP. Being White British (adjusted odds ratio 1.39, 95% confidence interval 1.15 to 1.72), having English as a main spoken language (adjusted odds ratio 1.51, 95% confidence interval 1.19 to 1.92) and living in owner occupied accommodations (adjusted odds ratio 2.29, 95% confidence interval 1.83 to 2.88) were statistically significant predictors of this response. White British patients (1.5%) were less likely than patients from the Other Ethnic Groups combined (2.7%) to report that they were rarely or never satisfied with the outcome of their visits ( $p < 0.0001$ ) (Fig 5.4E).

Fig 5.4E

*Satisfaction with outcome of visit*



**Table 5.4K Satisfied with the outcome of the visit to the GP.**

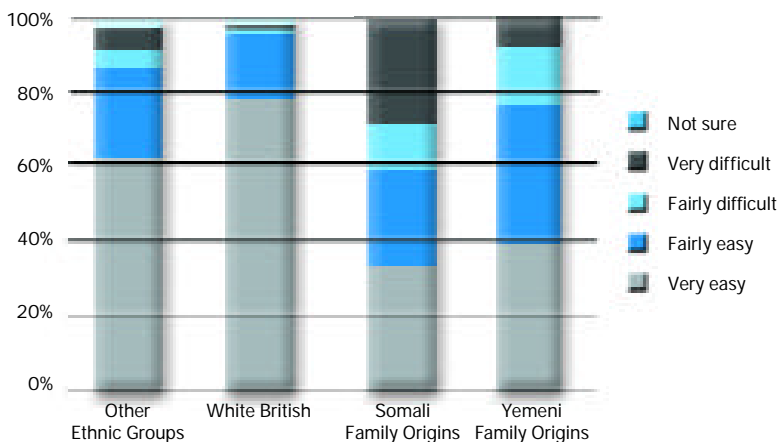
Response	Percentage of patients from Other Ethnic Groups	Percentage of White British Patients
Always satisfied	44.1	46.0
Most times satisfied	35.8	43.0
Sometimes satisfied	13.0	6.9
Rarely satisfied	2.0	1.2
Never satisfied	0.7	0.3
Not sure	4.4	2.5

**5.4.8 Understanding the GP.**

Most patients (92.0%) responded that it was very or fairly easy to understand the GP. However, 10.9% of patients from the Other Ethnic Groups combined reported that this was fairly or very difficult as compared to 2.2% of White British patients ( $p < 0.0001$ ) (Fig 5.4F). Considerably higher proportions of patients of Somali (39.5%) and Yemeni (22.4%) Family Origin responded that it was fairly or very difficult to understand their GP. Patients whose main language was English (adjusted odds ratio 3.64, 95% confidence interval 2.79 to 4.75) and patients living in owner occupied accommodation (adjusted odds ratio 2.94, 95% confidence interval 2.17 to 3.97) were more likely to respond that it was very or fairly easy to understand the GP.

Fig 5.4F

*Understanding the GP*



**Table 5.4L Ability to understand the GP by ethnic group.**

Response	Percentage of patients from Other Ethnic Groups	Percentage of White British Patients
Very easy	62.1	77.7
Fairly easy	24.3	17.8
Fairly difficult	5.3	1.6
Very difficult	5.6	0.6
Not sure	2.6	2.3

**Table 5.4M Ability to understand the GP - Somali and Yemeni Family Origin.**

Response	Percentage of patients of Somali Family Origin	Percentage of patients of Yemeni Family Origin
Very easy	32.6	37.9
Fairly easy	25.8	35.9
Fairly difficult	12.1	14.6
Very difficult	27.4	7.8

**5.4.9 Having an interpreter when visiting the GP.**

An interpreter was always or most of the time available for about a half of patients (52.5%) who spoke no English at all but for less than a half (44.9%) of those who spoke a little English. However, for almost one quarter of patients who spoke no English at all (21.3%) and almost one third of those who spoke only a little English (30.3%) an interpreter was rarely or never available (Fig 5.4G).

Fig 5.4G

Availability of an interpreter

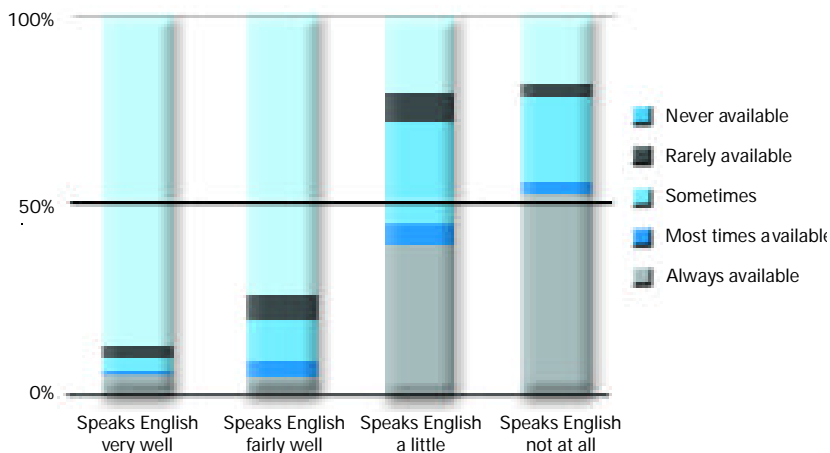


Table 5.4N Interpreter available when seeing GP.

Response	Speaks English very well	Speaks English fairly well	Speaks English a little	Speaks English not at all
Always available	4.3	3.7	39.4	52.5
Most times available	1.4	3.7	5.5	3.3
Sometimes	3.6	11.0	26.6	23.0
Rarely available	2.9	6.6	3.7	3.3
Never available	87.7	75.0	24.8	18.0

5.4.10 Choice of interpreter.

For patients who spoke no English at all a paid interpreter was the most common choice of interpreter (63.9%) (Table 5.4O). About a quarter (26.2%) of these patients identified a family member as their choice. Similar percentages of patients who spoke a little English chose a paid interpreter (43.9%) or a family member (41.1%) as their choice.

Table 5.4O Choice of interpreter.

Response	Speaks English very well	Speaks English fairly well	Speaks English a little	Speaks English not at all
A family member	53.8	44.8	41.1	26.2
A friend	10.1	15.5	7.5	6.6
A paid interpreter	28.6	36.2	43.9	63.9
Other person	7.6	3.4	7.5	3.3

## LIFESTYLE CHOICES

### 5.5.1 Smoking

5.5.1 (i) Ever smoked. Seventy two percent (72.0%) of all patients, male and female, 16 years and over, reported to have smoked at some time in their lives. White British patients (79.9%) were more likely to have done so as compared to patients from the Other Ethnic Groups combined (59.0%) ( $p < 0.0001$ ). This higher prevalence of having ever smoked among White British patients remained when analyses were limited to male or female patients only ( $p < 0.0001$ ).

**Table 5.5A** Prevalence of having ever smoked

	Male	Female
White British	82.4%	78.3%
Other Ethnic Groups	69.0%	51.6%

5.5.1 (ii) Present smoker. More than a third of patients 16 years and over (36.4%) reported that they were present smokers. Of the patients who had smoked at some time in their lives 62.7% were present smokers. White British patients who identified themselves as having smoked at some time were less likely to be present smokers (61.0%) as compared to patients from the Other Ethnic Groups combined (67.6%) ( $p = 0.001$ ). This higher prevalence of present smoking among patients (who had smoked at some time in their lives) from the Other Ethnic Groups combined was evident among female as well as male patients.

**Table 5.5B** Prevalence of present smoking

	Male	Female
White British	58.5%	60.4%
Other Ethnic Groups	63.4%	64.7%

5.5.1 (iii) Amount smoked - present smokers. On average present smokers smoked 14 cigarettes per day ranging from one cigarette to 80 cigarettes per day. The median number of cigarettes smoked per day was 12 cigarettes. Present smokers who were White British (15 cigarettes per day) smoked on average more cigarettes per day than present smokers from all the Other Ethnic Groups combined (13 cigarettes per day) ( $p < 0.0001$ ).

5.5.1 (iv) Passive smoking. Sixty four percent of patients who were not present smokers reported exposure to cigarette smoke in an average day. For 21% of these individuals at home was the place where they experienced most exposure to other peoples' cigarette smoke.

### 5.5.2 Alcohol consumption

5.5.2 (i) Prevalence of alcohol consumption. Twenty eight percent (28%) of patients (male and female) reported that they never drank alcohol. Forty percent (40%) drank alcohol once a week or more often and twenty seven percent (27%) less than once per week. There was no response to this question from five percent (5%) of patients. White British patients were more likely to drink alcohol than patients from the Other Ethnic Groups combined ( $p < 0.0001$ ). Eighty one percent (81%) of patients of Somali Family Origin and eighty five percent (85%) of patients of Yemeni Family Origin reported that they never drank

**Table 5.5C** Prevalence of alcohol consumption

Alcohol consumption	White British	Other Ethnic Groups combined	Total
Once a week or more	49%	26%	40%
Less often than once a week	30%	21%	27%
Never drink alcohol	18%	44%	28%
No response	3%	9%	5%
Total	100.0%	100.0%	100.0%

5.5.2 (ii) Amount of alcohol consumed. On average, patients who drank alcohol once a week or more often, consumed 8.2 units of alcohol per week (Range 1 unit to 70 units per week). White British patients consumed on average 8.5 units per week as compared to 7.2 units for patients from the Other Ethnic Groups combined ( $p = 0.005$ ).

5.5.2 (iii) Symptoms of excessive alcohol consumption. Twelve percent (12%) of patients who drank alcohol once a week or more often, reported to have had shaking hands in the morning after drinking alcohol or needing a drink of alcohol first thing in the morning to steady their nerves. These patients drank on average 14.3 units of alcohol per week.

# 6



Data  
Interpretation

### 6.1.1 (i) Ethnicity

Data from the Patient Information Form (PIF) indicated that patients from Black and Minority Ethnic (B&ME) communities accounted for 38.3% of patients 16 years and over. This was considerably higher than the estimates for B&ME populations within the electoral wards of Granby, Abercromby and Smithdown (Table 1.2A) as well as the Primary Care Team's own estimate of the percentage of patients from B&ME communities registered with the practice. In the Primary Care Act Pilot application for example (PCAP Application 1997), B&ME patients were reported to represent 20% of the practice population. Patients who considered themselves to be Black British represented the largest of the minority ethnic groups. This choice of ethnic identity might reflect the significance of British born status (see Section 6.1.2) or a lessening of the importance of the cultural heritage of immigrant parents. This group is expected to continue to be one of the fastest growing minority ethnic groups in the North West of England, in Liverpool (Lee et al., 1996) and in the practice population at the Princes Park Health Centre. Additionally, this trend towards an increasing proportion of patients from B&ME communities in the practice population is reflected in the finding that more than half of patients (50.4%) aged 16 to 25 years belong to some other ethnic group other than White British.

### 6.1.1 (ii) Family origin

Self-defined ethnicity as proposed by the Office of Populations Censuses and Surveys (OPCS) for the 1991 census and used in the PIF does not allow easy classification into ethnic subgroups. In light of this shortcoming an exploration of family origins was carried out in addition to self-defined ethnicity. In this way patients of Somali and Yemeni Family Origin could be identified. These groups accounted for 5.1% and 2.7% of the practice population respectively and represented a smaller proportion of patients 16 years and over in the practice population than was expected based on the subjective view of the Primary Care Team. However, it should be noted that this view took into account the larger sizes of some B&ME families.

### 6.1.2 Country of Birth

The finding that the vast majority of Black British patients (88%) were born in Britain with the majority of their mothers born in Britain as well as consistent with findings from the OPCS 1991 census and the more recent Policy Studies Institute survey of Ethnic Minorities in Britain (Modood et al., 1997).

### 6.1.3 Marital status

White British patients were less likely to be married than patients from the Other Ethnic Groups combined and this is consistent with findings from national surveys (OPCS 1991; Health Education Authority 1994; Modood et al., 1997). However, the proportion of White British patients who were married or living with a partner (34.6%) was considerably lower than would have been expected from these surveys. This would support the view that there exists a high proportion of lone parents in the practice population.

#### **6.1.4 Language and literacy**

Limited English language and literacy competence is a well-documented barrier to services for B&ME patients and it would appear that this applies to these groups of patients at the PPHC (Hopkins and Bhal, 1993; Hawthorne and Tomlison, 1999). For 39.6% of patients from the Other Ethnic Groups combined, English language was not their first language. For more than half (53%) of these patients their English Language competence was described as being able to speak "a little" English or "not at all". Clearly, for these patients such limited English would severely compromise consultations with the Primary Care Team. Further, the ability to speak a language, even when that language is the individuals' first language, does not imply the ability to read that language well or even at all. This brings into question the strategy of using written non-English translations for informing patients whose first language is not English. In the case of patients with Somali or Arabic as their first language, approximately 20% only read these languages "a little". A further 18% of Somali speakers did not read any language. Additionally, it should be noted that at least 3.4% of patients read no language at all with almost half of these patients being White British. This re-emphasises the point that ability to read ones' first language should not be assumed even for White British patients.

#### **6.1.5 Socio-economic status**

Patients registered with the PPHC were less likely than individuals in Liverpool, in general, to own their homes, a car or be employed (Central Policy Unit 1993). Among the patient population, White British patients were better off, on these indicators, than patients from the Other Ethnic Groups (Sections 5.25(i) - 5.25(iv)). These findings are consistent with results from other national and local surveys, which explored the socio-economic characteristics of B&ME populations (HEA 1994; Modood et al., 1997; Lakey 1997). Home ownership, car ownership and employment provide proxy measures of socio-economic status, which has consistently been shown to be an important determinant of health and access to health care (Whitehead 1992; Drever and Whitehead, 1999; Marmot and Wilkinson, 1999). Based on this evidence therefore, the health and health care experience of the patient population at PPHC would be expected to be worse than that of the population of Liverpool in general and the health and health care experience of B&ME patients even more so.

#### **6.1.6 Religion**

Evidence is accumulating of the positive impact of religion on health (Karlsen et al., 1998). The finding that White British patients (30.4%) were more likely to report that they did not have a religion compared to patients from the Other Ethnic Groups (13.7%) might therefore put this group at a disadvantage. White British patients at the PPHC were as likely as White British individuals elsewhere in Britain (31%) to report not having a religion (Modood et al., 1997). Not surprisingly, the major religion among patients from the Other Ethnic Groups was Islam (32.3%), this being the major religion of people of Somali and Yemeni family origin.

## HEALTH AND ILLNESS

### 6.2.1 Self perceived health

On average patients considered their health considerably worse than that of individuals surveyed in the Health and Lifestyles Survey of B&ME groups in England (HEA 1994). In this survey 8% of the general population considered their health less than good as compared to 20.7% of patients at PPHC. Consistent with previous local and national surveys, the Other Ethnic Groups reported worse health than White British patients did (HEA 1994; Nazroo 1997). These findings support the view that the patient population at PPHC, particularly patients from B&ME communities, experience considerably poor health. It would appear however that the poorer health experience of patients from B&ME communities is determined mainly by factors associated with their lower socio-economic status.

### 6.2.2 Factors impacting most on health

The factors that patients considered impacted most on their health were similar to those identified for the UK population from the Health and Lifestyles Survey (HEA 1994). Weight and smoking were rated highly among the most important causes of ill health in this survey and among patients at PPHC. Patients at PPHC were however more likely to consider the psychosocial factor "worries at home" as the most important factor affecting their health. Crime was not considered the most important factor by many patients although Liverpool 8 is considered one of the areas of the City with high crime rates. The finding that patients from the Other Ethnic Groups were more likely to identify housing as the factor impacting most on their health might reflect the poorer housing conditions of these patients.

### 6.2.3 On medication

A remarkably high proportion of patients was on some type of medication at the time of interview. It was not possible however, from the information collected, to determine how much of this was doctor prescribed medication. This high prevalence of medication use might reflect the level of perceived ill health in this population.

### 6.2.4 Doctor diagnosed ill health - self reported

#### 6.2.4 (i) Hypertension and Stroke - self reported

The prevalence of self reported hypertension of 18% recorded for the patient population at PPHC (White British and Other Ethnic Groups) was higher than that reported for individuals in Britain (12%) (Modood et al., 1997). This higher prevalence was not unexpected however since the PPHC patient population clearly did not reflect the characteristics of the general UK population. The similarity in the prevalence for White British and patients from the Other Ethnic Groups combined however reflected the national trend. The high prevalence of stroke (12% in patients over 65 years) might be a consequence of the high prevalence of hypertension and possibly a reflection of the poor levels of hypertension control (Stewart et al., 1999).

#### **6.2.4 (ii) Angina - self reported**

The prevalence of angina in the PPHC patient population was similar to that reported for the White British and B&ME populations in Britain (14% and 15% respectively) (Nazroo 1997). The prevalence in Somali and Yemeni patients was more in keeping with the prevalence reported for Pakistani and Bangladeshi populations in Britain (25%) (Nazroo 1997). Self-ascribed ethnicity remained an independent predictor of self-reported angina after adjustment for age, sex, socio-economic status and having ever smoked suggesting that ethnicity might be a proxy for other factors that increase the risk of coronary heart disease among B&ME populations.

#### **6.2.4 (iii) Diabetes - self reported**

The prevalence of diabetes among White British PPHC patients (5.0%) (40 years and over) was higher than that reported for White British individuals (40 years and over) in Britain (Nazroo 1997) and in other parts of the country (Smaje 1995; Simmons 1992; McKeigue et al., 1991). As for angina, self-ascribed ethnicity remained an independent predictor of self-reported diabetes after adjustment for age, sex and socio-economic status again suggesting that ethnicity might be a proxy for other factors that increase the risk of diabetes among B&ME populations. The prevalence of diabetes among patients of Yemeni Family Origin was similar to that reported for Bangladeshi and South Asian populations in other studies (Bhopal et al., 1999; Modood et al; 1997; Smaje 1995).

#### **6.2.4 (iv) Myocardial infarction - self reported**

The finding that White British patients were no less likely to report having had a heart attack than patients from the Other Ethnic Groups combined 5.3% vs. 6.6% was surprising since White British patients reported a significantly lower prevalence of angina (10.1% vs. 16.8%). This finding could be explained by a higher fatality rate after a myocardial infarction among patients from the Other Ethnic Groups. This higher fatality rate could in turn be a consequence of patients' limited understanding of their illness as well as barriers which they face in accessing appropriate health care (Chaturvedi et al., 1997).

#### **6.2.4 (v) Asthma - self reported**

Comparisons with other national studies on the prevalence of asthma are difficult but it would appear that the prevalence of self reported asthma (18.2%) is considerably higher among patients at PPHC than nationally (11%) (Ormerod et al., 1999; HEA 1994). Unexpectedly, damp housing was not a statistically significant predictor of self-reported asthma.

#### **6.2.4 (vi) Depression**

The finding that 15.8% of patients from all ethnic groups reported that they were sad, miserable or depressed always or most times is consistent with the view that there is a considerable amount of depressive illness among the practice population. This level of depressive illness was higher than that recorded in other surveys (Shaw et al., 1999; HEA 1994). It would appear that a significant amount of this depressive illness among patients at PPHC might be related to being alone and isolated.

#### **6.2.5 Family history of ill health**

The consistently lower prevalence of a family history of illness for all diseases explored in the PIF might reflect limited recall or knowledge of family illnesses and not necessarily a lower prevalence of these conditions among family members.

## PATIENT SATISFACTION

### 6.3.1 GP preference

The finding that patients from the Other Ethnic Groups were more likely to prefer to see a same sex GP, than White British patients was consistent with the results from a number of other surveys (Ahmad 1994; HEA 1994; Nazroo 1997). However, almost a quarter (24.2%) of patients who preferred to see a female GP normally saw a male GP considerably higher than the 10% reported for the general UK population (HEA 1994). The finding that a number of patients usually saw a female GP when for them it either did not matter (23.7% of patients for whom it did not matter) or they preferred to see a male GP (4.9% of patients who preferred to see a male GP) suggests that patients' preferences could be better satisfied by more appropriate allocation of patients to general practitioners.

### 6.3.2 Physical access to PPHC

Less than 10% of patients considered getting to PPHC as being fairly difficult or very difficult and there was no statistically significant difference between White British patients and patients from the Other Ethnic Groups. Difficulty in getting to PPHC is therefore unlikely to be an important reason for under utilisation of preventive and other services.

### 6.3.3 Time spent waiting for an appointment or to be seen

A quarter of patients reporting that they had to wait much too long to get an appointment to see their GP is clear indication that further exploration of this issue is required. Not surprisingly patients from the Other Ethnic Groups were more likely to express unhappiness than White British patients. Patients from the Other Ethnic Groups were also more likely to report that they waited much too long to be seen within the health centre. These findings are consistent with those from other surveys (HEA 1994; Smaje 1995; Nazroo 1997).

### 6.3.4 Time spent with GP

Few patients (5.3%) reported that the time spent with their GP was rarely or never long enough. This is reassuring for a health centre, which has tried to extend consultation time as much as possible, for example, increasing consultation time to 20 minutes for patients requiring an interpreter. However, there remains a small proportion of patients for whom further innovations may be required. As expected patients from the Other Ethnic Groups were more likely to report that the time spent with their GP was rarely or never long enough. For about half of these patients language was most likely the issue, which required the consultation time to be longer.

### 6.3.5 Able to talk about problems you want to talk about

Most patients (79.5%) reported that they were able to talk about things they wanted to talk about with their GP. This is consistent with the view that most patients thought that the time spent with their GP was long enough.

### 6.3.6 Satisfaction with the outcome of the visit

Most patients (85.5%) reported that they were always or most times satisfied with the outcome of their visit to the GP. This has been a consistent finding from interviews with individual patients and from patient focus groups. It reflects the consistent efforts of the Primary Care Team to improve the quality of the service provided at the PPHC. However, White British patients, patients whose main language was English and patients who were better off (lived in owner occupied accommodation) were more likely to be satisfied with the outcome of their visits. This suggests that a more targeted approach to improving the quality of health care provided may now be required.

### 6.3.7 Language and interpreter issues

Considerably high proportions of patients of Somali and Yemeni Family Origin (39.5% and 22.4% respectively) reported that it was fairly or very difficult to understand their GP and for these patients interpreter services would be required. Views on whether this interpreter should be a paid interpreter or a family member are variable. This finding suggests that before the decision is made to have a paid interpreter present during a consultation the individual views of the patient should be sought. Further, other than English proficiency, socio-economic status may play a role in predicting patients' ability to understand the GP with patients who are better off being more able to do so.

## 6.4

## LIFESTYLE CHOICES

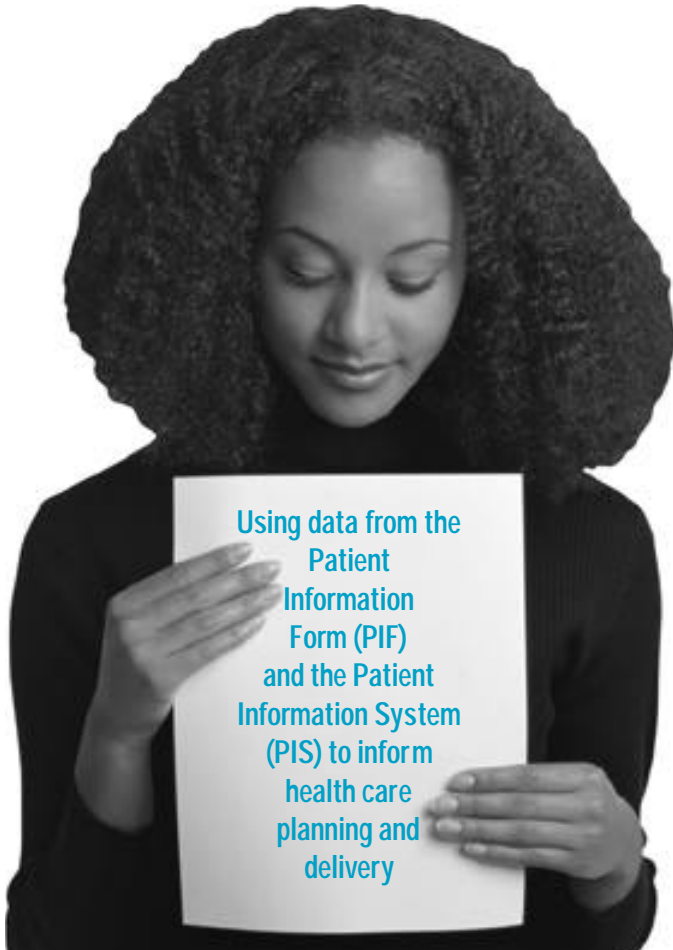
### 6.4.1 Smoking

The prevalence of having ever smoked among all patients at PPHC (72.0%) was similar to that identified for the general UK population (73%) (HEA 1994). Among White British patients however it was considerably higher, 79.9% as compared to 61% for White British nationally (Nazroo 1997). The prevalence of having ever smoked among patients from the Other Ethnic Groups (59.0%) was considerably higher than that recorded for South Asians in the Health and Lifestyles survey (Indians 22%, Pakistanis 29%, Bangladeshis 32%) (HEA 1994) and for all ethnic minorities in the Policy Studies Institute's study of ethnic minorities in Britain (Nazroo 1997). It was about the same as that recorded for African Caribbeans (55%) in the Health and Lifestyles survey (HEA 1994). Present smokers represented 36.4% of the patient population considerably higher than the prevalence of current regular smokers among the general UK population (28%) (HEA 1994). The prevalence of present smokers among patients who had smoked at some time in their lives from the Other Ethnic Groups (67.6%) was also higher than that for White British patients (62.7%) and for minority ethnic groups identified in the Health and Lifestyles survey (HEA 1994). White British patients however smoked more cigarettes on average. This evidence does not support the commonly held view that smoking prevalence is low amongst minority ethnic populations. It is more in keeping with more recent findings, which suggest that the prevalence of risk factors such as smoking among minority ethnic groups should be, re-evaluated (Bhopal et al., 1999). Further, this evidence also suggests that the impact of present smoking cessation interventions might be less effective for these groups of smokers and indeed might not reach them at all.

### 6.4.2 Alcohol consumption

The prevalence of alcohol consumption among patients from the Other Ethnic Groups was low and reflected the very low consumption among patients of Somali and Yemeni Family Origin. Of concern was the significant percentage (12%) of patients who drank alcohol once or more per week and who displayed signs suggestive of alcohol dependence.

# 7



Using data from the  
Patient  
Information  
Form (PIF)  
and the Patient  
Information System  
(PIS) to inform  
health care  
planning and  
delivery

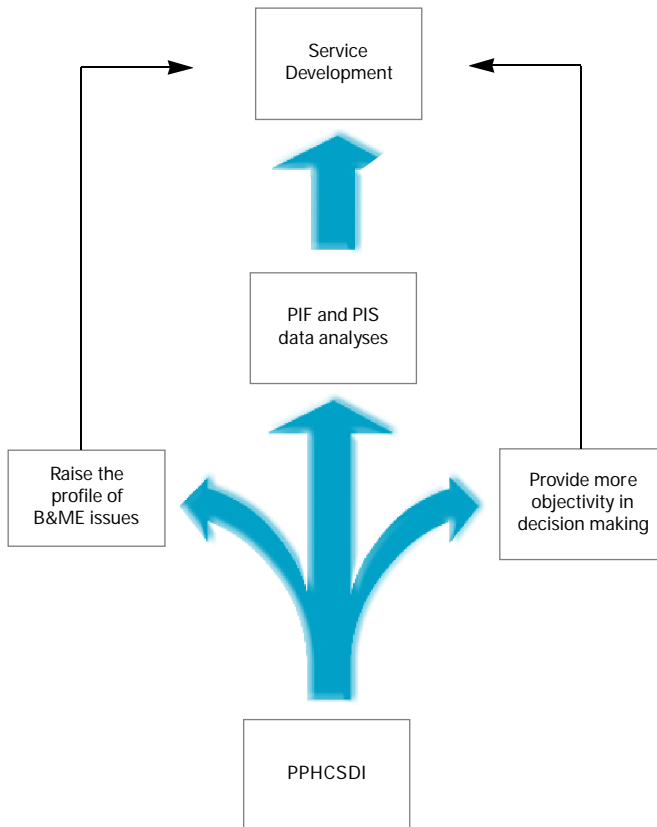
## INTRODUCTION

As discussed elsewhere in this report, the planning of this initiative and the process of collecting patient information, on their own, did a great deal to raise the profile of a number of issues within the Primary Care Team. Issues of access to services for Somali and Yemeni patients and the quality of health care for elderly patients and for those with chronic diseases, for example, became frequent topics for discussion.

When data collection had been completed many opportunities arose to use the information collected to directly inform decisions about health care provision and to stimulate discussion and action on ways of improving quality of care (Fig 7.1A). Some examples of these are presented here.

Fig 7.1A

### *Improving the Quality of Health Care*



## INITIATING A STRATEGY FOR REDUCING MORBIDITY AND MORTALITY FROM CORONARY HEART DISEASE (CHD) AMONG BLACK AND MINORITY ETHNIC GROUPS

7.2.1 There has been, for some time now, considerable evidence that establishes the increased morbidity and mortality of CHD among some minority ethnic groups. British Indians, British Pakistanis and British Bangladeshis in particular, have been shown to experience considerably greater risk of not only developing CHD but also dying from its consequences. Little however is known about the effect of this condition among other minority ethnic groups, for example British Somalis and British Yemenis.

7.2.2 There was the view among health care providers at the PPHC that patients of Somali and Yemeni Family Origin might as well have a predisposition to developing this condition and there was considerable interest in investigating what the situation might be for these groups. More importantly, there was keen interest in reviewing the delivery of primary, secondary and tertiary preventive CHD related health care services for these patient groups.

7.2.3 The following represents analyses which were carried out in the initial stages of the exploration of the relationship between ethnicity and CHD among patients at PPHC.

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**Table 7.2 A (i) History of Angina - PIF Data (Patients 25 years and over)**

History of Angina	
White British	6.7%
Other Ethnic Groups	10.6%
Total	8.1%

Patients who classified themselves as White British were much less likely to report a history of angina than patients from all other ethnic groups combined ( $p < 0.0001$ ). For patients born in Somalia and the Yemen or those whose mothers or fathers had been born in Somalia or the Yemen, the prevalence of reported angina was considerably higher.

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**Table 7.2 A (ii) History of Angina - PIF Data (Patients 25 years and over)**

History of Angina	
Somali Family Origin	20.9%
Yemeni Family Origin	13.2%

In contrast, surprisingly lower ethnicity specific prevalences were computed after combining the data collected through the PIF with information available from the Patient Information System. From this data source White British patients (25 years and over) recorded a prevalence of angina of only 4.2% and non-White British patients a prevalence of 3.8%. This inconsistency was a cause for much concern in particular since the PIF data analysis provided estimations of the same order as that of recent national surveys (Nazroo 1997).

7.2.4 The following represents some of the issues that were considered.

1. Data on disease morbidity obtained from self-administered questionnaires in both national and local surveys are of questionable validity.
2. There are differences between patients' and clinicians' views as to the cause of patients' symptoms.
3. The difficulty in retrieving data from the Patient Information System can give rise to under estimates of disease prevalence.
4. Disease coding on the PIS is incomplete.

7.2.5 Additionally, the PIF data suggested that the prevalence of reported myocardial infarction among White British patients (3.5%) was similar to that for patients from the Other Ethnic Groups combined (4.1%). There was no statistically significant difference in the prevalence of myocardial infarction between these groups ( $p = 0.454$ ). The considerable difference in the prevalence of angina between these groups, all things being equal, should have produced a similar difference in the prevalence of myocardial infarction.

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**Table 7.2B History of Myocardial Infarction - PIF Data**

History of MI	
White British	3.5%
Other Ethnic Groups	4.1%
Total	3.7%

7.2.6 There were a number of possible explanations for this absence of a statistically significant difference. The one which provoked most concern however and definitely could not be ignored, was the explanation that patients from the Other Ethnic Groups were indeed more at risk of ischaemic heart disease, did have myocardial infarctions more frequently but died more frequently from their heart attacks than White British patients, either because of the severity of their infarctions, the health care which they received or some other outcome related factor.

7.2.7 This concern has led to a review of CHD related mortality in the health centre practice population and a review of the provision of primary, secondary and tertiary preventive care for at risk groups. Both reviews are presently ongoing and are expected to bring about some fundamental changes in the ways in which health care is provided for patients with CHD and for those most at risk of death from myocardial infarction. In addition, a healthy heart clinic has been established with an active recall system for patients with ischaemic heart disease. Link-workers and interpreters are available at this clinic when required.

## INFORMING THE STRATEGY FOR SPECIAL CLINIC SESSIONS

7.3.1 There was the suggestion, based on the views of some members of the health centre team, that introducing "special" clinic sessions for patients of Somali and Yemeni Family Origin might be an appropriate way of improving the quality of health care services offered to these patients. Some key issues underpinning this view were those related to language difficulties experienced during consultations, the unsuitability of the appointment procedures and the perception that Black and Minority Ethnic patients would prefer to be seen by same sex GPs. It was hoped that the PIF data analysis would provide some objective data to support this suggestion and help to win over the less convinced members of the health centre team.

7.3.2 The following lists some of the findings from the data analyses (Section 5) which were presented to support the proposal for "special" clinic sessions.

- Male and female patients of Somali and Yemeni Family Origin were more likely to prefer to be referred to same sex GPs than White British men and women.
- Patients of Somali and Yemeni Family Origin were the most likely to complain of having difficulty understanding their GP and their GP having difficulty understanding them. This was most likely a consequence of the limited English language competence of these patients.
- Patients of Somali and Yemeni Family Origin were the most likely to complain of having to wait too long in the waiting room or to get an appointment to see a GP.
- Patients of Somali and Yemeni Family Origin were most likely to complain of not having enough time with their GP.

## INFORMING THE STRATEGY FOR SMOKING CESSATION

7.4.1 Smoking has been identified in the Department of Health's White Paper - Saving Lives - as the single biggest preventable cause of poor health. It was not surprising therefore that the PCT was very keen to be able to describe patterns of smoking among the practice population. It hoped to use this as a starting point for developing a more effective strategy for reducing smoking among groups of present smokers in particular heavy smokers and for informing strategies for limiting the initiation of smoking among young people.

7.4.2 The following was obtained from an analysis of data from the Patient Information Form (Section 5).

\* Seventy two percent (72.0%) of the practice population 16 years and over (77.1% of men and 68.6% of women) reported that they had smoked at some time in their lives. For the White British patients the prevalence of having ever smoked was 79.9%. For patients from the Other Ethnic Groups it was 59.0% ( $p < 0.0001$ ).

\* More than a third (36.4%) of the practice population 16 years and over were present smokers. For White British patients the prevalence of present smoking among those who had smoked at some time in their lives was 62.7%. For patients from the Other Ethnic Groups it was 67.6% ( $p = 0.001$ ).

7.4.3 There was a commonly held view that smoking was not as common among minority ethnic populations as among White British populations. This belief led to more emphasis on smoking interventions being placed on White British patients. The evidence coming from the data collected on the PIF however did not support this view. It suggested that whereas White British patients were more likely to have tried smoking at some time in their lives they were less

likely to have continued smoking. Patients from the Other Ethnic Groups were more likely to have remained smokers once they had tried it. This evidence required a review of the emphasis of smoking interventions on White British smokers and the suitability of these interventions for smokers from the Black and Minority Ethnic communities.

## INFORMING DECISIONS ABOUT DNAs

**7.5.1** Appointments which are not cancelled and for which patients do not attend (DNA) are of considerable concern to health centre staff since they prevent these appointment slots from being used by other patients. In the past, there had been several attempts to address this issue but these efforts were hampered by a lack of objective data on the reasons why patients did not attend. Factors which were often considered to be predictors of whether patients were more likely to not attend appointments or not included ethnicity, sex, difficulty getting to the health centre and socio-economic status.

**7.5.2** The following analyses represent the beginning of an ongoing process at PPHC of understanding and resolving the issue of DNAs.

- There were 2264 appointments with GPs during the month of January 2000. For 188 (9.7%) of these, the patients did not attend (appointments not cancelled). Of the patients 16 years and over attending the health centre during January 2000, 60% were White British patients and 40% were patients from the Other Ethnic Groups combined. White British patients were no less likely to have consulted their GP during this month than patients from the Other Ethnic Groups combined ( $p = 0.231$ ).
- Patients from the Other Ethnic Groups combined were no more likely to have not attended for their appointments ( $p = 0.565$ ) or cancelled their appointments ( $p = 0.653$ ) than White British patients.
- Male patients were no more likely to have not attended their clinic appointments compared to female patients ( $p = 0.554$ ).
- Patients who were unable to read or speak English were no more likely to have not attended their clinic appointments compared to patients who could read or speak English ( $p = 0.665$ ).
- Patients who reported that they found it fairly or very difficult to get to the health centre were no more likely to have not attended their clinic appointments compared to patients who reported that they found it very easy or fairly easy ( $p = 0.744$ ).
- Patients who lived in rented accommodation were no more likely to have not attended their appointments than patients who lived in owner occupied accommodations ( $p = 0.058$ ).
- Patients who owned or had access to a car were no more likely to have attended their appointments than patients who did not own a car or did not have access to one ( $p = 0.148$ ).

**7.5.3** The evidence that none of the factors, which were initially considered predictors of patients who were more likely to miss appointments, were significantly related to non-attendance suggested that interventions to reduce the number of non attenders which focused on these factors were unlikely to be successful. This has led to the suggestion that whether patients attended their appointments or not might be related more to the nature of the appointment and the time from making the appointment to the actual appointment date. This issue is presently being investigated.

## **OTHER WAYS IN WHICH THE INFORMATION IS PRESENTLY BEING USED (IN BRIEF)**

### **7.6 Other ways in which the information is presently being used (in brief)**

#### **7.6.1 Breast Screening programme**

**7.6.1 (i)** The PIF data has been used alongside data from the Breast Screening programme to identify and target health education initiatives at women from Black and Minority Ethnic communities who have not taken up the offer of breast screening.

#### **7.6.2 New Home Energy Efficiency Scheme**

**7.6.2 (i)** The New Home Energy Efficiency Scheme is part of the government's strategy to help people whose health is most at risk from cold and damp housing. It aims to provide vulnerable households, with a focus on owner occupied households and private rented households, with complete packages of insulation and heating improvements. The PIF data was used to identify patients who would be entitled to and would benefit most from this scheme.

#### **7.6.3 Informing Health Living Centre proposals**

**7.6.3 (i)** The PIF data was used to inform the proposals for a Healthy Living Centre in Liverpool 8. An application for funding is about to be submitted.

#### **7.6.4 Highlighting clerical staffing needs**

**7.6.4 (i)** The PIF data was used to provide persuasive arguments for the need for Arabic and Somali speaking staff.

#### **7.6.5 Identifying focus group members**

**7.6.4 (i)** The PIF data was used to identify patients from the different ethnic groups who would be willing to attend focus group meetings.

#### **7.6.6 Identifying minority ethnic patients with neurological problems.**

**7.6.4 (i)** The PIF data was used alongside the PIS data to identify Black and Minority Ethnic patients with neurological problems so that they could be introduced to the services offered at the Glaxo Neurological Centre.

#### **7.6.7 Informing epidemiological health care needs assessment**

**7.6.7 (i)** Steps in epidemiological health care needs assessment using both disease based and life cycle approaches have been initiated.

#### **7.6.8 Informing the Positive Action Training programme**

**7.6.8 (i)** The PIF data was used to support the successful application to the Liverpool City Council for a Positive Action Trainee from the local Yemeni community. Her work has strengthened the argument within the local Primary Care Group for an increase in hours allocated for Yemeni linkworkers.

#### **7.6.9 Informing the development of the Sports Action Zone Initiative**

**7.6.9 (i)** The PIF data supplied information to the Sports Action Zone Initiative about teenage and adult smoking and alcohol consumption.

Further opportunities for the use of this data are arising daily and there is considerable interest from other local organisations including Liverpool City Council.

8



Community  
Partnership

8.1

Identifying initiatives that would improve the quality of health care and overcome the barriers to accessing services required insights, which could only be provided by users of the service. Establishing a partnership with patients was therefore an essential step in the process of developing these initiatives. Partnership however implied ownership by all concerned and the sharing of responsibilities and power.

8.2

The Primary Care Team therefore had to relinquish some of its hold on the authority for decision making to patients and there was some resistance to this. It needed to be assured that patients did have an appropriate understanding of the constraints to health care delivery but additionally it needed to appreciate the advantage of having lay expertise to inform decision making. Patients in turn needed to have an appropriate understanding of how NHS organisations worked and to appreciate that the Primary Care Team was genuinely interested in improving the quality of care that they provided. Both needed to be acquainted with the ways in which focus groups were established and used to address issues that were of interest to everyone.

8.3

The Centre for Health Healing and Human Development in the School of Health and Human Sciences at Liverpool John Moores University and Liverpool Healthy City were approached to provide a training programme for members of the PCT and patients representing the majority and minority ethnic groups. This training programme which ran over six evenings, one evening per week for six consecutive weeks, sought to explore with participants how a focus group involving health care providers and users could be used to identify ways of improving the quality of health care. Participants received a certificate of attendance at completion of the programme.

8.4

The first issue addressed by the focus group was the appointment system at PPHC and the proposals from the group were fed back to the Primary Care Team during a two-hour workshop for all staff. These proposals are presently being considered by the management team at the health centre.

# 9



Conclusions

9.1

From its inception in 1977, Princes Park Health Centre has had a Primary Care Team which has been considered to be forward thinking and innovative. Over the years, the health centre had been involved in a number of successful innovations aimed at improving health and health care delivery. This openness to introspection and innovation was an important contributory factor to the success of the Service Development Initiative (SDI).

9.2

However, some members of the PPHC team did not consider more vigorous attempts at ethnicity profiling appropriate as other priorities seemed more pressing. There was scepticism that more information, in the absence of more resources, could lead to better health care. When emerging information indicated that change was necessary, there was still some resistance to creating systems to bring about these changes. This occurred even when changes did not require additional resources. This resistance to change, on the part of some members of the health centre team, was an important challenge for the Service Development Initiative. To overcome it required presenting the evidence for change in a way that could not be ignored and ensuring that staff as well as patients would benefit from the proposed changes.

9.3

The Service Development Initiative was successful in establishing morbidity, mortality and service utilisation profiles of the patient population at Princes Park Health Centre and was able to demonstrate how these could be used to inform decisions about health care provision. As a result of the SDI, significant changes in health care provision at PPHC are underway, aimed at creating a more user friendly and appropriate service.

9.4

Ethnicity profiling at Princes Park Health Centre is now viewed as an essential step in assessing the health needs of an ethnically diverse patient population. In addition, it is regarded as an important step to providing high quality health care. Primary Care Group Central West and Liverpool Health Authority have embraced this perspective and the Service Development Initiative's role in bringing this about has been one of its key successes. It is this perspective that drives the commitment to carry on the work that the SDI has begun.

9.5

As the work of the Service Development Initiative progressed considerable effort was put into sharing the experience gained in ethnicity profiling, specifically the Princes Park Health Centre model, with other health centres in Liverpool and elsewhere in the North West of England. As a direct result of these efforts, the PPHC model has been adopted by the Primary Care Group Central West in Liverpool, which has also provided the resources for the ethnicity profiling of, initially, ten other GP practice populations in Liverpool. Fifteen other practices are expected to be included at a later date.

9.6

The Service Development Initiative was also able to influence or initiate a number of other activities aimed at improving the health of Black and Minority ethnic communities. A number of these were clearly and directly linked to the original aims and objectives of the SDI. Others came about as a result of efforts to encourage and support health care providers to undertake ethnicity profiling. In addition, some key achievements arose out of the credibility in matters related to Black and Minority Ethnic health which the SDI team acquired. The following lists, in brief, the achievements of the Service Development Initiative.

### **9.6.1 Advisory role**

9.6.1.(i) Adviser on ethnic profiling in Primary Care to -

- Primary Care Group Central West (Liverpool, Merseyside)
- Liverpool Health Authority
- Bury and Rochdale Health Authority
- Wigan and Bolton Health Authority

9.6.1.(ii) Adviser on Black and Minority Ethnic health issues to -

- NHS Executive North West
- Liverpool Health Authority
- North Mersey Community Health Care Trust
- Liverpool John Moores University School of Health and Human Sciences

### **9.6.2 Education and training**

9.6.2.(i) Inclusion of a module which explores issues related to the health of Black and Minority Ethnic communities on the Bachelor of Science degree programme in Public Health at Liverpool John Moores University (LJMU).

9.6.2.(ii) Inclusion of a module which explores valuing ethnic diversity on the Bachelor of Science degree programme in Public Health at Liverpool John Moores University.

9.6.2.(iii) Inclusion of a module which explores valuing ethnic diversity on the Bachelor of Arts degree programme in Nursing at Liverpool John Moores University.

9.6.2.(iv) Training of PPHC staff in the use of the PIF database.

9.6.2.(v) Training of the PPHC staff in ethnicity data collection.

9.6.2.(vi) Training of the Garston Health Centre staff in the use of the PIF database.

9.6.2.(vii) Training of the Garston Health Centre staff in ethnicity data collection.

9.6.2.(viii) Establishment of teaching links between the School of Health & Human Sciences (LJMU) and the Liverpool Moslem Society.

9.6.2.(ix) Establishment of teaching links between the Liverpool School of Tropical Medicine and the SDI.

9.6.2.(x) Establishment of links between Liverpool John Moores University and North Mersey Community Trust to continue the ideas and vision of the initiative.

### **9.6.3 Information systems**

9.6.3.(i) Establishment of a data collection and a data analysis system for Princes Park Health Centre.

9.6.2.(ii) Updating of patient addresses and telephone numbers at Princes Park Health Centre.

9.6.2.(iii) Establishment of a data collection and a data analysis system for Garston Health Centre.

### **9.6.4 Community development**

9.6.4.(i) Establishment of a PPHC-Community Group.

9.6.4.(ii) Facilitation of the Liverpool 8 Healthy Living Centre work group.

### **9.6.5 Service development at PPHC**

#### **9.6.5.(i) Use of practice data for service evaluation and development.**

- Exploration of health centre utilisation and access to the Primary Health Care Team.
- Audit of the prevention and treatment of coronary heart disease.
- Evaluation of the uptake of cervical cytology.
- Evaluation of the uptake of breast screening services.
- Audit of hypertension in the Black Caribbean community.

#### **9.6.5.(ii) Employment of a multi-lingual member of staff.**

#### **9.6.5.(iii) Employment of a Positive Action trainee from the Yemeni community.**

#### **9.6.5.(iv) Introduction of multi-lingual practice leaflets, appointment cards and notice boards (on going).**

#### **9.6.5.(v) Production of a multi-lingual information video (on going).**

### **9.6.6 Advancement of ethnicity profiling.**

#### **9.6.6.(i). The extension of the work carried out at PPHC to initially ten other GP practices in Liverpool Primary Care Group (Central West).**

9.7

The work carried out at PPHC was made possible by a grant from the Department of Health. This enabled the centre to profile its patients extensively providing information which could be used to improve health care delivery in diverse ways. Setting up the systems to collect this information was resource intensive but need not necessarily be so in the future since the PPHC SDI has already developed a model for patient profiling. With increased realisation of the worth of this information, we must think of new ways to free resources to enable patient profiling to take place in other practices.

# 10



Recommendations  
for ethnicity  
profiling

**COLLECTING INFORMATION ON ETHNICITY.**

**10.1.1** An opportunistic approach to collecting data on ethnicity, used on its own, is not recommended for practices wishing to establish ethnic profiling as a means of improving access to health care services for population groups defined by ethnicity. This approach is unlikely to provide information for a large enough proportion of the patient population to allow valid population analyses within a reasonable time frame. Further, it is likely to exclude patients who do not or are unable to access the services being offered.

**10.1.2** A patient information form mailed out to patients and supported by an appropriately worded letter from the Primary Care Team, is likely to be the most cost-effective way of collecting information from the patient population. The supporting letter should set out, clearly and concisely, the reasons for collecting this information. It should also explain that this would be used to update the present patient information system. No more than two mailings are recommended.

**10.1.3** The collection of information on ethnicity should be part of a wider information gathering exercise as it provides an opportunity to update patient records and to acquire and use information not previously collected. This approach would enhance the cost-effectiveness of the data collection exercise and would make it more applicable to the wider practice population.

**10.1.4** Special attention must be paid to the design and appearance of the patient information form and for this professional advice should be sought. Advice should include recommendations from epidemiologists, community workers, community members, social scientists, the Primary Care Team and others involved in the collection of similar information.

**10.1.5** The production of patient information forms printed in a variety of languages is not recommended unless there is reasonably accurate information available about the language preferences and literacy of the practice population. However, the patient information form should contain a short statement in the most commonly used languages explaining the purpose of the form and how further information about it could be obtained.

**10.1.6** Members of the Primary Care Team who will provide assistance to patients in completing the patient information form must receive the appropriate training in interviewing techniques. Instructions must be well defined and documented.

**10.1.7** Interpreters who will be assisting non-English speaking patients must be trained in administering the patient information form. Attention must be paid to the way in which questions in English are translated into other languages. Issues of cultural appropriateness and language characteristics must be considered. Instructions for interpreters must be well defined and documented.

**10.1.8** For new patients ethnicity profiling must be an integral part of the routine data collection process. This information must be collected at the time of first registration.

**10.1.9** Most importantly every effort must be made to involve and to encourage the participation of administrative and clinical staff at all stages. Training of staff and the provision of opportunities for the debate of contentious issues are essential. For this external facilitation is advised.

**10.1.10** The frequency with which this whole data collection exercise should be repeated will depend on the data items (see 10.2) which have been collected. Data items, which will not change over time, for example country of birth, will not need to be collected again. However, information on patient characteristics which are likely to change, for example health status, will need to be updated at intervals.

## 10.2

### DATA ITEMS

**10.2.1** The information collected must above all reflect what is required for improving the quality of services provided. Information available from other sources need not be duplicated. The format of the patient information form must follow its function.

**10.2.2** Data obtained from the patient information form should be comparable with other local, regional or national data sets. If this is possible the added value of the data collected will be greatly enhanced.

**10.2.3** Questions on ethnicity should explore both individuals' perceptions of their own ethnicity as well as the individuals' family origins (theirs and their parents' countries of birth).

## 10.3

### WORKING WITH COMMUNITY LEADERS

**10.3.1** It is important to have a general impression of the views of community leaders before their support and advice is sought with regard to any initiative on ethnicity profiling. In particular, an understanding of their possible concerns should be obtained. They may not be as enthusiastic as hoped and they can have both positive as well as negative influences on communities' willingness to participate. Although their support can be beneficial, their ability to assist in securing a good response rate for the patient information form should not be overestimated. Community groups might not view ethnicity profiling as an issue which has a high priority on their agenda.

## 10.4

### IMPROVING PATIENT RESPONSE RATES

**10.4.1** A good response rate for the patient information form depends mainly on patients having a clear understanding of why it is necessary to collect this information. Informing patients that the information will also be used to update patient files and that it is now part of the registration process will also be useful. User friendly form design, the provision of support to patients who require it and the encouragement provided by the Primary Care Team in the accompanying letter and during interactions with patients will also be essential.

## 10.5

### ESTABLISHING A DATABASE

**10.5.1** Entering the data obtained from completed patient information forms on to an electronic database is essential.

**10.5.2** This database must allow the retrieval of information on individual patients as well as analyses at the patient population level.

**10.5.3** Present general practice computerised patient information systems provide good access to information on individual patients. However, the population analyses which are often required for making decisions about service planning are usually less accessible. More in depth population analyses may require the use of other computer software packages such as the Statistical Package for Social Sciences (SPSS).

**10.5.4** If unfamiliar computer software is to be used for data input and analyses the training of staff in its use will be required.

## 10.6

### DATA ANALYSIS

**10.6.1** Data collection must lead to data analyses and then to the use of these analyses to improve the quality of services provided.

**10.6.2** As with other data, the patient information form data must always be kept safe and secure. At least two data back ups must always be kept.

**10.6.3** At least two representatives from the various categories of staff in the Primary Care Team must have access to the data and be competent in its analysis. This may require training.

## 10.7

### DATA USE AND IMPROVING THE QUALITY OF HEALTH CARE.

**10.7.1** Patient profiling is an essential step to health care needs assessment. Primary Care Groups and Trusts provide the environment, resources and opportunities for this to happen and will be the most powerful level for this information to be used.

**10.7.2** Unless there is already a well-established culture, within the Primary Care Team, of using objective data to inform decision making, there must be concerted efforts to encourage and facilitate this. The appointment of a senior member of the team to this role will facilitate this process. Initially, Primary Care Teams may require support and expertise from Public Health and other departments in Health Authorities and Trusts. Ideally, Primary Care Teams should aim towards having individuals within the team with sufficient knowledge of data collection, analysis and interpretation.

**10.7.2** Improving the quality of health care often requires changes to medical and administrative procedures and protocols. Bringing about these changes may require far greater effort and skill than was required for data collection and analysis. Expertise in "managing change" will be essential and if not available within the Primary Care Team it must be acquired from outside of the team.

**10.7.3** Sustainable improvements in the quality of services will require multi-disciplinary involvement in planning changes. Users of the service must play a real part in the service planning process. Whenever representatives of the patient population are consulted they must be appropriately compensated for their time. Changes to procedures and protocols may also require additional resources or the redistribution of the resources already available.

**10.7.4** Developing and nurturing community partnerships will require informed efforts on the part of the Primary Care Team. Community representatives will require an insight into health service organisation and the planning and delivery of health care. Members of communities and the Primary Care Team, who will be most involved in these partnerships, should be trained together.

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## QUESTIONNAIRE

If you require copies of the questionnaire being used at Princess Park Health Centre or the questionnaire with the recommended minimum data set, please contact either Dr. Bennett Lee or Dr. Katy Gardner at Princes Park Health Centre.

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