Black and Ethnic Minority (BME) health - background

Little did I realise that this seemingly throwaway remark, from a professional in Social Care, would form the essence of my project on Black and Minority Ethnic (BME) health in Oxfordshire.

Minority issues are important. Aside from moral and social arguments to reduce inequalities in health, the issue of equality is now enshrined in law and policy.

The NHS itself was founded on the twin principles of equity of access and equity of treatment. Box 1 outlines some key pieces of legislation and policy that require public authorities such as the NHS to take positive steps to promote equality.

Box 1: Legislation and policy on racial equality.

- The Race Relations Amendment Act (2000)
- Equality Bill
- The NHS Constitution.
- DH’s Strategic Objectives: better health, better care and better value for all.
- World Class Commissioning Competencies
- Putting People First – transforming adult social care.
- Next Stage Review: ‘minimising the health effects of disadvantage’.
- Personalisation.
- Various White Papers e.g. Choosing Health.
- NSF for older people, healthcare commission.

Despite this, however, some ethnic groups are repeatedly shown to have poorer health outcomes, particularly in certain clinical areas, such as diabetes, cardiovascular disease and mental health. It appears, thus, that there is a discord between legislation, policy and practice.

In an area such as Oxfordshire, there is also a growing BME population. Although it is not as large, nor as vocal, as in other parts of the country, arguably there exists similar, if not greater, potential for marginalisation.
The nature of the problem

A key part of my project was to scope and define the problem locally, using a mixture of taught management tools, such as PDSA cycles and Ishikawa analysis, along with self-designed approaches, applied to different settings.

I was particularly fortunate to have spent my clinical days with a local practice that has a significant number of BME patients, along with refugees and asylum seekers. I was able to carry out research within this ‘model’ practice as well as to draw from their considerable experience - in particular Richard Stevens, who has known many individuals from the local community for years, and from whom I learned the fundamental importance of face-to-face communication and relationship building. It also enabled me to experience first hand some of the challenges faced by health care professionals in caring for these groups.

Some key themes emerged from the scoping exercise: the intangible and heterogeneous nature of ethnicity, language and communication issues, GP engagement and dialogue between disparate service providers.

The essence of ethnicity and the social determinants of health

Ethnicity is heterogeneous: its fluidity and shifting nature mean that it evolves, often in response to a particular political and socio-economic milieu. It is both assigned and adopted. Perhaps this is why it is such a seemingly intractable issue for policymakers: it does not lend itself easily to targets and measurable outcomes. Whatever local or national policy measures are adopted must address this fundamental element.

Furthermore, there is increasing evidence to suggest that some of the poorer health outcomes in certain BME groups may not be attributable to some inherent ‘genetic’ component of ethnicity but, rather, to shared environments of disadvantage. The literature base informed my subsequent actions: in particular it led me to view Social Care as inextricable from Health and to examine the relationship between these agencies more closely.

Language and communication.

There are many disparate services and agencies and a lack of dialogue between these different stakeholders. As an example, early on in the project, having made an appointment to meet someone at East Oxford Health Centre, I arrived at the wrong office. It took twenty minutes of conversation (and a very nice cup of tea) before realising that I was in the wrong place: this team were doing such similar work yet had no communication with the team I had intended to meet in the very same building! At a subsequent PCT meeting a very salient point was raised: in this current financial climate, when it is most required, rather than working collaboratively, organisations within the NHS are contracting, become insular and defensive.
Partnership building and trust.

There is a tendency for BME groups to access services through known individuals rather than through mainstream processes. This again highlights the importance of working together, with shared goals and consistent messages.

The overwhelming message I received over the six month period was the importance of engaging GPs in BME care. GPs are well placed to identify the health and social needs of BME populations and to signpost them to appropriate support. Unfortunately, as the title quotation suggests, this is not always perceived to be an easy task.

In order to create an impact, therefore, my areas of focus were twofold: firstly, partnership building with and amongst the many different groups that provide services to BME users. Secondly, the contribution of a ‘GP voice’ to PCT and local authority priorities. This happened at three levels: strategic, grass roots and education.

Strategic

As a clinician afforded the luxury of time during this post, I felt able to somewhat mitigate the palpable perception GPs are key players but too busy to engage with PCTs and local authorities. I engaged early with the County Council and contributed to a Joint Adult Social Care Equality Assessment. I was invited to attend a Strategic Equality Leads Group meeting and to consult with a Service Development Manager in charge of joint commissioning. I also forged links with the health advocates team at the PCT. During these processes I was also able to feed back some of the challenges and realities I faced as a working GP.

Grass roots and education

As someone relatively naïve to management speak and organisational silos, I felt it important to ‘keep things real’. Therefore I also linked with third sector organisations, such as OCVCA, the Migration Impact Fund and the Carer’s centre, as well as local community groups. For example, during the swine flu pandemic I delivered a lecture highlighting key public health messages to a local Hindu community group.

Recognising and responding to a gap between existing technology and it use, I disseminated an innovative web-based translation tool to local GPs. I was invited to facilitate a teaching session to trainee GPs on diversity and have been working with my ST4 colleague Aimee Lettis to create an educational video about asylum seeker experiences.

The six months culminated in a presentation to the Executive Board of the Strategic Health Authority.
The leadership programme

The Fellowship experience is highly recommended. Using the Medical Leadership Competency Framework (MLCF) and specific educational tools to enhance generic skills acquired through vocational training, the programme aims to nurture primary care leaders who will contribute to organisational change and improved patient care, both locally and nationally.

From a personal point of view, the programme gave me the time and flexibility to design, plan and implement a project independently, within the supportive and stimulating environment of a regular learning set. The corollary to this was that working alone, without a team or resources, presented a significant number of challenges that required lateral thinking to resolve.

Within the learning set, different leadership styles were explored and nurtured; it became apparent to me that a quiet, collaborative approach could work just as well as a more vociferous style. This experience gave me the confidence to achieve a number of the Leadership Competencies of the MCLF at an early stage in my career.

The allocated time for personal development was also important and utilised in different ways. Locally, I was able to gain a valuable insight into quality assurance of GP training by participating in a training assessment visit and subsequently by acting as a Registrar representative on the Appointments Committee. A mentoring process also enabled me to maintain formal links with my wonderful ST3 trainer. Further afield, I was invited to be a Panel Member at an RCGP breakfast discussion meeting on leadership, chaired by Professor Steve Field. The Director of Leadership at the Department of Health was present and I was able to put forward my views on the importance of leadership skills for juniors, as well as to act as an ambassador for the Oxford Leadership programme. The meeting will be reported in the Health Services Journal. There were also opportunities for research, writing and attendance at conferences. Above all, though, it was fun and I wish it could have lasted another six months!

From a broader perspective, it is my hope that introducing GPs to leadership at an early stage will lead to a professional culture wherein our daily practices of innovation and problem-solving in the face of complexity and uncertainty can be channelled toward wider policy and public health issues.

The challenge now is to create systems that will support all GPs, and not necessarily those in formalised leadership or executive roles, to be able to do this. Leadership happens at many levels and can often work best from the grass roots upwards. It is therefore important for all GPs - including junior GPs - to feel valued within the NHS and empowered to engender change where necessary to improve patient care. Leadership programmes such as this can further the understanding of the nexus between policy, practice and the patient.

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