Evaluation of

Kensington & Chelsea and Westminster Health Authority

Facing Up to Difference Strategy

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1 EXECUTIVE SUMMARY

1.1 Aims and Objectives

1.1.1 This report evaluates Kensington & Chelsea and Westminster Health Authority's Facing Up to Difference Strategy (FUD) which was published in July 1998 and covered a three year period.

1.1.2 It was a strategy for the commissioning of health services in ways which respond to the needs of the Black and ethnic minority communities (BME) in Kensington and Chelsea, and Westminster.

1.1.3 The key objective of the Strategy was to work towards reducing unacceptable variations in health status and in the experience of using health services where such variations are attributable wholly or partly to ethnicity and/or cultural differences.

1.2 Evaluation Method

1.2.1 Our evaluation involved semi-structured interviews with the key individuals responsible for implementing the Strategy from the key stakeholder organisations, and from key community and voluntary groups. A list of the individuals interviewed can be found in Appendix 1, page 77. The timetable for this evaluation did not allow for in-depth consultation with BME communities and community groups on their views of the Strategy and its impact on service planning and delivery.

1.2.2 The research was conducted between December 2001-March 2002. It considered the following main areas:

- the extent to which the Strategy has provided a framework for health equalities work for the Health Authority, PCGs and Trusts
- the impact of the Strategy's five principles for commissioning for an ethnically diverse population:
    - ◊ information on BME communities
    - ◊ health needs of BME communities
    - ◊ access to services
    - ◊ appropriate services
    - ◊ recognising variations in BME communities.
- the significant developments in health policies and structures since the Strategy was agreed in July 1998
- issues for the future.

1.3 Findings

A framework for health equalities work for the Health Authority, PCGs and Trusts

1.3.1 The Health Authority's Facing Up to Difference Strategy has had an impact on the work of the Health Authority, the PCGs and the Trusts to address health inequalities caused by ethnicity.

1.3.2 Through the FUD Strategy Group, leadership for equalities work was provided to the Health Authority, PCGs and Trusts. That the Health Authority Chief Executive chaired the Group was a significant factor in this achievement.

1.3.3 The Strategy, through the Steering Group, has encouraged the PCGs and Trusts to give organisational ownership and to develop their own local equalities policies and action plans. The Steering Group has also provided a forum for accountability for health equalities work in the two boroughs.

1.3.4 The flexibility of the Strategy has also allowed issues and organisational structures which were not present when it was formulated in 1998, e.g. workforce diversity, regeneration schemes and the development of PCGs, to be taken account of and incorporated.

Information on BME communities

1.3.5 The Social Mapping Project was a very ambitious project but it did not achieve its objective.

1.3.6 The Project did show that many organisations collect BME data. However, if such a database is to be developed in future, there is a need for the organisations involved to agree an effective methodology to improve data collection, aggregation and utilisation.

1.3.7 There are differences in opinion as to whether the approach adopted by the Project of a 'database of databases' was the right one or necessary, given the alternative datasets available.

1.3.8 The requirements of the Race Relations (Amendment) Act 2000 will mean that sustainable mechanisms for obtaining reliable data on the BME communities need to be in place. In order to learn from the experience of the Social Mapping Project, the stakeholders should re-agree what data is needed, how this can best be obtained, aggregated and used to plan and monitor health services.

Health needs of BME communities

1.3.9 Despite the failure of the Social Mapping Project, the Health Authority has been able to obtain a range of data about the health needs of the BME population.

1.3.10 The BME Health Forum, through its policy work and Task Groups, has played a significant role in conducting research and providing information about the BME communities and their health needs, as well as developing the engagement of these communities with health commissioners and providers.

1.3.11 The Health Improvement Programme refers to the FUD Strategy and recognises that BME residents may have specific health needs. It is also clear that the Health Authority, PCGs, and local authorities have an awareness of the importance of these issues.

1.3.12 Overall, action to address the needs of older people from the Black and ethnic minority communities seems most advanced than for any other client group.

1.3.13 However, most outputs from the Programme have a timescale of 2001. This is understandable given the imminent organisational changes but does mean that a picture of the longer term direction of health equalities work is not yet available.

1.3.14 The national policy framework for addressing the needs of Black and minority ethnic service users in the NHS is not strong. Although considerable emphasis is placed on tackling inequalities, ethnicity has not been explicitly recognised as a factor in this.

Access to services

1.3.15 There has been a broad range of initiatives to provide information about, and help support BME communities to gain access to, health services. A number of services have addressed the specific needs of asylum seekers and refugees.

1.3.16 The services provided by GRIP (and latterly by CITAS for Riverside) has enabled providers to have access to interpreting and translating services. However, there were criticisms of the management of GRIP from some Trusts.

1.3.17 The Health Authority and Trusts have provided a broad range of training for their staff on equalities issues.

1.3.18 The BME Health Forum has been the formal mechanism set up by the Health Authority to consult and involve the BME communities in the planning and delivery of health services. As such, it has played a key role in developing BME community links with the Health Authority and Trusts.

Appropriate services

1.3.19 The Health Authority has provided or commissioned a range of services to help GPs meet the needs of the BME communities.

1.3.20 The Health Authority has responded to the gap in appropriate GP services by securing funding the GP Vocational Training Scheme for eight refugee doctors. The doctors speak a variety of languages and half are women.

1.3.21 All the provider Trusts have adopted an equalities policy and action plan based on Facing Up to Difference to help them work towards providing an ethnically and culturally appropriate service to the BME communities.

Recognising variations in BME communities

1.3.22 The BME Health Forum has been an effective means by which the BME communities can develop and strengthen their links to the health sector in Kensington and Chelsea, and Westminster. Through participation in the Forum's policy work and Task Groups, the BME communities can provide direct input on their experiences and expectations of health services.

1.3.23 The Forum's participation in other policy groups and fora help to ensure that the Facing Up to Difference Strategy is widely disseminated and that other initiatives are aware and take account of BME health issues.

1.3.24 The advent of the Race Relations (Amendment) Act 2000 with the requirement that each Trust sets up a Race Equality Scheme will mean that the BME Health Forum will have an important role in involving and consulting with the BME communities on these issues.

Local initiatives and partnership development

1.3.25 A range of local initiatives to meet the health needs of the BME communities have been set up, consistent with FUD criteria.

The local authorities and FUD

1.3.26 As originally conceived, the FUD Strategy was a strategy for the Health Authority focusing on health issues. The two local authorities - the City of Westminster and the Royal Borough of Kensington and Chelsea - covered by the Health Authority participate in the Facing Up to Difference Strategy Group.

1.3.27 Since the adoption of the Strategy, the partnership agenda has moved on significantly. For example, the Disability Discrimination Act 1995, the Race Relations (Amendment) Act 2000, the Best Value regime, the development of Local Strategic Partnerships and local authority scrutiny and overview of the health economy, the setting up of two borough-based primary care trusts.

1.3.28 These policy and organisational changes will result in more in-depth partnership work with many stakeholders, including the health sector. The requirements of the Race Relations (Amendment) Act 2000 will mean that the two local authorities will focus more strongly on equality issues in future, including health equality issues.

1.4 Conclusions

1.4.1 Nearly half the UK's Black and ethnic minority population live in London, constituting a quarter of London's population. It is a population which is characterised by diversity and heterogeneity across London and within each borough. Planning for and delivering health services to people with such diverse needs is a major challenge for the health sector.

1.4.2 Kensington & Chelsea and Westminster Health Authority's Facing Up to Difference Strategy established a strategic framework for the commissioning of culturally sensitive health services. It enabled the Health Authority to:

- attempt to improve its data on the Black and ethnic minority communities
- involve and consult with the minority communities through the BME Health Forum
- enabled it to take account of the health needs of these communities in its planning processes, such as the Health Improvement Programme
- encouraged Trusts to develop their own strategic equalities framework for their workforce and patients
- provided a framework for the two primary care groups to develop their own equalities strategy which can be taken forward by the about to be established primary care trusts
- led to specific services to meet need.

1.4.3 There will be a continuing need for an equalities strategy to engage both commissioners and providers because:

- there is substantial evidence to show that BME communities generally suffer poorer health and have less access to health services than the majority population
- there are morbidity and mortality profiles which specifically affect ethnic minorities
- there are increasing expectations from the minority (and majority) communities for the NHS to be more responsive to the health and health care needs of specific groups in the population
- the effective and equitable delivery of health services to the BME communities is an important Government priority.

1.4.4 The next 18 months will be period of great organisational change for the health sector nationally and in the City of Westminster and the Royal Borough of Kensington and Chelsea. The Strategy can still provide a useful framework for the next three years, taking into account the changes in policies and organisational structures since it was agreed in July 1998.

1.4.5 Overall, the task will be to continue to ensure that attention and action to achieve equitable access and service delivery permeates each Trust and becomes integral to their service delivery.

1.4.6 More specifically, this will require that commissioners and providers have adequate data on the needs and health outcomes of the minority communities; that the barriers to accessing health services are tackled through language support, advocacy and culturally specific services where appropriate; that meaningful involvement with these communities is continued and further developed.

1.4.7 In the next phase of work, there needs to be more explicit links from national research on need, to the identification of particular local needs, to prioritising action, to implementing action and evaluating it. This should involve:

- an agreed equalities framework for the PCTs and Trusts in the two boroughs
- continuing co-operation and co-ordination between these bodies and other key local stakeholders
- an increasingly rigorous approach to the setting of performance indicators and monitoring of every aspect of the Strategy.

2 INTRODUCTION

2.1 Background

2.1.1 In 1996, the Kensington & Chelsea and Westminster Health Authority (KCW) commissioned the Migrant and Refugee Communities Forum to audit KCW's performance on health services for Black and ethnic minority groups using the King's Fund toolkit 'Facing Up to Difference'.

2.1.2 The Migrant and Refugee Communities Forum subsequently appointed CVS Consultants to undertake this work and a final report was accepted by the Health Authority's Board in December 1996. Work then started to draw up a strategy for KCW.

2.1.3 As part of the work in drawing up a strategy, an audit of KCW's work on health and ethnicity during the previous three years was undertaken. The audit indicated that to take this work forward in a more structured way, KCW intended to:

- make explicit the policy objectives in the form of principles, both for internal and external use
- set out a framework for choosing priorities for work
- identify priorities and a plan for tackling them
- provide a means of holding the Health Authority to account for the strategy
- bring together a number of strands of current work.

2.1.4 The new strategy was also intended to avoid the pitfalls of:

- assuming that being part of an ethnic minority community equals a health problem
- setting out a lengthy, descriptive analysis of problems and issues
- setting out lofty, vague and possibly unachievable statements of intent.

2.1.5 The new Facing Up to Difference Strategy (FUD) was published in July 1998 covering a three year period. It was to a strategy for the commissioning of health services in ways which respond to the needs of the Black and ethnic minority communities in Kensington and Chelsea, and Westminster.

2.2 Health Needs

2.2.1 There was a need for such a strategy because the KCW:

'population is complex, containing many different groups of residents who would define themselves as minority ethnic communities. Many of these communities are small. Between 75 and 95 first languages are spoken, although information is poor and the absence of universal definitions makes it difficult to establish agreed data... information derived from the 1991 census is only of very limited help as it gives "numbers of residents born outside the UK" which is not of itself a particularly useful indicator of ethnic and cultural diversity and need. KCW aspires to the principle of equity in health care in terms of access, outcome and geographical spread, and we intend to make our commissioning of services responsive to need. Finally, we are committed to making the services we commission as sensitive as possible to the individual needs of each and every resident. Given the diversity of our population, these are challenging aspirations, the achievement of which must be a clear priority in our own work and in the work of partner organisations'.

'Our belief is that there are unacceptable variations in access to services, whether for reasons of culture, language or knowledge, and in the experience of using the NHS. Other variations may result from genetic predisposition to certain conditions, in morbidity and in outcomes'.

'In some cases the variations are because of ethnicity alone. A correlation with social inequalities exists (although to unpick this and prove it scientifically would be a major piece of work in its own right). Whether variations result from the health system, the socio-economic environment in which an individual lives, or from his or her genetic makeup, **our key objective is to work towards reducing unacceptable variations in health status and in the experience of using health services where such variations are attributable wholly or partly to ethnicity and/or cultural differences.**'[1]

2.3 Commissioning for Minority Communities

2.3.1 FUD formulated five principles specific to the commissioning of services for an ethnically diverse population covering:

1 Information about residents

To commission health care for an ethnically diverse population, good information is required. The Health Authority, in partnership with other local organisations, will put in place an information system designed to provide an accurate assessment of the

[1] KCW Facing Up to Difference Strategy, July 1998

numbers and geographical distribution of the ethnic minority communities living in KCW.

2 Needs of residents

Health needs may be influenced by ethnicity, including greater or lesser susceptibility to certain diseases. The Health Authority will improve its understanding of the full range of its residents' needs, with reference to specific conditions and diseases.

3 Access to health services

Access to health services, including health promotion and prevention programmes, may be hindered by language and/or culture. The Health Authority will work to improve access, both through targeted initiatives for agreed priorities and through fostering a widespread awareness of communication difficulties. It will work with providers to improve these.

4 Appropriateness of health services

People's experience of health care may be negative because of a lack of consideration of cultural expectations. The Health Authority will work with service users and providers to share understanding of cultural expectations and develop staff skills and processes. The appropriateness of care delivery in the (routine) monitoring of service delivery will be picked up.

5 Variations in local communities

Communities change over time, particularly as newly arrived groups, including refugees, settle in and age. The Health Authority will recognise that ethnic communities are not homogenous and that their knowledge, experience and expectations of the health service will vary.

2.4 Priorities for Local Initiatives

2.4.1 Drawing together the information mapping work, the needs assessment work and the provider audits, priority areas for action and an implementation plan would be agreed. Initiatives which addressed the health needs of Black and minority ethnic communities would be supported if they met the following criteria:

- tackle the greatest variations in health status where these are attributable wholly or partly to ethnicity and where action to achieve greater equity is possible
- are, or foreseeably can be, integrated with mainstream services
- are consistent with the principles of the Health Authority's Five Year Strategy
- primarily focus on health needs, as opposed to needs which are the proper business of other agencies, or are identified as joint responsibilities with other organisations

- produce measurable benefits in terms of increased access to or uptake of services or which can provide evidence of improvements in the experience of people using the services
- engage the commitment of service providers, whether in primary care, in community services or in hospital Trusts
- improve the information about the communities the Health Authority serves.

2.5 Implementing Change

2.5.1 FUD recognised that change may be managed in many ways, for example, through education, audit, information or commissioning through service agreements. This would involve working with or through communities themselves, local clinicians and managers, the local authorities, other local organisations (such as employers), and Health Authority staff, to equip them to facilitate change in others and, for front line staff, to deliver an appropriate service.

2.5.2 The Strategy envisaged that the Health Authority's role would vary, sometimes to influence others to act differently, sometimes through facilitation and co-ordination, sometimes through more direct action.

2.6 Facing Up to Difference Strategy Group

2.6.1 To show the commitment of the Health Authority to this area of work, a senior officer steering group was set up to implement the Strategy. This was replaced later by the FUD Strategy Group, which meets every three months. It is chaired by the Chief Executive of the Health Authority and composed of senior officers from the local PCGs and Trusts, the two Social Services departments, the Community Health Council and representatives of the voluntary sector from the two boroughs.

3 ETHNICITY AND HEALTH

3.1 Introduction[2]

3.1.1 The 1991 Census recorded 6.2% of the population and 4.5% of households in England as from a BME group. London is the most ethnically diverse city in the UK. Latest population projections suggest that around 25% of Londoners belong to a Black or minority ethnic group, nearly half of the UK's BME population.

3.1.2 The importance of health for BME populations in London has been identified as one of the four key priorities for the London Health Strategy. The Strategy was published in March 2000 and is a London-wide strategy to improve the health and well-being of Londoners. Its aim is to support work to improve health and reduce health inequalities at local and national levels by focussing on London-wide activities that can reinforce and boost initiatives in London. It focuses on four key areas (regeneration, inequalities, transport, BME health) which consultation indicated offered the greatest potential to support efforts across all levels of activity in the capital.

3.1.3 The Greater London Authority set up the London Health Commission in October 2000 to oversee the development and implementation of the Strategy, and to ensure that health considerations are integrated into all key London-wide strategies.

3.2 Ethnic Monitoring of Service Activity

3.2.1 One of the most basic requirements for monitoring inequality in relation to service use is the ability to record ethnic group along with other activity information. This particularly applies to the large computerised data sets that are used in strategic planning and financing. In the NHS, ethnic coding of computerised hospital admission data was introduced in 1995, and ethnic group is now a mandatory item.

3.2.2 One of the problems with these data is the levels of ethnic coding that are being achieved in practice. An analysis (1999) looking at hospital episode data for the London Region suggests that in 1996-7 only 50% of records were coded but that this improved to 63% in 1997-8.

[2] This section is based on data from the London Health Observatory Black and Ethnic Minority Populations report, and Sector Study 11: Black and Ethnic Minority Communities Key Data, Housing Corporation.

3.2.3 Whilst the data are so incomplete there is a natural reluctance to use them, and so few analyses using this data have been undertaken.

3.2.4 The issue of ethnic coding also applies to other aspects of the health service and related services. Ethnic coding in general practice is being piloted in the NHS in London and some other areas: data collection has not yet been underway for long enough to produce useable results. Ethnic coding is not yet part of the national patient registration system.

3.2.5 Language and religion are other important dimensions of ethnicity, which ideally should be recorded and used at the strategic as well as the service delivery level.

3.3 Ethnicity and Health Inequality

3.3.1 Ethnicity can be an important factor in health inequality between ethnic groups as a result of differences between ethnic groups in:

- determinants of health, e.g. age, sex, gender, genetics, income, employment, education, housing, social networks, mobility, migration
- prevalence of disease or of behaviour and lifestyle that have differential health risks, e.g. diabetes, renal failure, cardiovascular disease, limiting long-term illnesses
- access to and uptake of services which are of potential benefit
- measures of health outcome or health status such as differences in mortality.

3.3.2 In order to be able to tackle inequality between ethnic groups, there needs to be intelligence in all four of these areas, and on the links between them.

Determinants of health

3.3.3 Whilst some factors such as age and sex differences are easy to deal with, many of the most important factors influencing health are much harder to take into account.

3.3.4 In particular, the interaction between risks linked with low income, unemployment, poor quality housing and low educational attainment can be difficult to untangle. These are especially important in terms of differences in health between ethnic groups.

3.3.5 For example, minority ethnic groups tend to have lower average incomes and higher unemployment.

Unemployment in Greater London at 1991 Census

	White	Non-White
Men	11.9%	21%
Women	7.6%	15.9%

3.3.6 In a more recent comparison (1998), unemployment amongst the White population was 6.5%, whilst the rate for Indians was 7.4%; Black groups 20.5% and Pakistanis and Bangladeshis 15.9%.

3.3.7 Analyses of the numbers of people on low income and living in poverty show a similar picture. A study in London of income distribution shows the stark differences between groups with 76% of the Bangladeshi population being amongst the lowest one fifth of income in London. All the minority ethnic groups had proportionately fewer people amongst the highest earning category.

Differences between the proportion of ethnic populations amongst the highest and lowest earners in London (1997)

Ethnic group	Lowest fifth of earners	Highest fifth of earners
White	13%	27%
Bangladeshi	76%	2%
Pakistani	36%	7%
Black African	35%	7%
Black Caribbean	30%	7%
Black Other	31%	10%
Chinese	27%	20%
Other	21%	17%
Indian	18%	11%

3.3.8 Income and employment are important determinants of health in their own right, and also have effects on a range of other social indicators such as housing. Geographical mobility can seriously affect access to services; and within the ethnic minority groups, the experience of and around migration is a key issue for a large - though decreasing and also ageing - proportion of people.

3.3.9 One of the concerns when looking at differences in health status and outcome is to consider the extent to which poorer outcomes amongst minority ethnic groups are a product of ethnic difference, or simply of deprivation. For a comprehensive view of the health of Londoners it is important to be able to recognise the links between ethnicity and these wider social and economic factors.

Disease prevalence and health related behaviour

3.3.10 There is a diverse and fragmented literature looking at differences in the prevalence of disease between ethnic groups.

Examples of conditions where prevalence is known to vary by ethnic group

Condition	Summary of patterns
Cancer	Mortality rates high amongst people born in Ireland. Lower rates for major cancers in those born in Indian subcontinent and (except cervical) Caribbean and African Commonwealth. Oral cancers high in South Asian, African groups.
Coronary Heart Disease	Mortality rates high in South Asian and White populations, and lower in Caribbean.
Diabetes	Lower rates of Insulin Dependent Diabetes (Type I) in South Asian and Caribbean populations. But much higher rates of Non-Insulin Dependent (Type II later onset). Higher rates of diabetes also linked with other conditions such as renal failure and coronary heart disease.
Mental Health	There is an over-representation of people of African Caribbean origin as admitted patients for schizophrenic illnesses and concern regarding mis-diagnosis. Asian and African Caribbean groups are under-represented as users of counselling and other services for depression.
Renal Failure	The risk of requiring dialysis treatment and/or transplant surgery is nearly 14 times higher for Asians than for White groups. Overall, the relative risk of renal failure in both Black and Asian populations compared to the White population is about three-fold and rises with age.
Stroke	Higher mortality rates amongst people from African and Caribbean commonwealth.
Thalassaemia	More common amongst people from Southern Europe, Middle East and South Asia.
Tuberculosis	High mortality amongst people born in Ireland. High incidence amongst new entrants to UK from South Asia.
Sickle Cell	Prevalent in African and Caribbean populations.

3.3.11 There is some evidence that families, and particularly children of BME origin are more likely to require medical treatment for accidents in or near the home. This is partly due to traffic patterns in inner city areas, poverty and overcrowding in the home.

3.3.12 Some of the problems with studies of particular conditions include:

- they can be old and from relatively small, sometimes incomplete samples
- many are not standardised for socio-economic or other health determinants
- definitions of ethnic group differ between studies, and from measurable population denominators
- studies may therefore not be generalisable
- there has been a focus on negative aspects of health amongst Black and minority ethnic groups, rather than positive ones
- there has been more emphasis on conditions where minority groups are relatively disadvantaged - including some rare and exotic diseases - than on those which are relatively more important to minority groups themselves, and where a targeted approach to health improvement would be justified.

3.3.13 Census data on limiting long-term illness provides another indicator of health status. In looking at these responses for London's pensioners, it was found that despite having a much older age profile than the non-White groups, White pensioners (36.1%) showed a below-average proportion reporting limiting long-term illness. Again Bangladeshi (45.9%) and Pakistani (45.5%) groups were more likely to do so.

Some examples of important differences in lifestyle and health related behaviour that can be linked to specific health conditions

• Smoking patterns have been shown to vary between different groups, with higher levels in Bangladeshi men reported in several studies; and high levels in both Caribbean men and women, while rates in all South Asian women are very low. Some of these differences reflect socio-economic and religious differences.
• Alcohol use varies in different ways, with lower rates reported by ethnic minority groups as a whole than by whites, but big differences between Caribbean and South Asian groups, and within the latter, between religions - Pakistanis and Bangladeshis, and Muslims from elsewhere, reporting very little drinking.
• Use of paan (betel nut), believed to be a risk factor in oral cancer, is high among some South Asian ethnic groups: again differences have been related to religion and also location of family origin, with Sikhism (as with smoking) and the Punjab associated with low usage.
• Dietary factors including cholesterol intake for South Asians have been cited as relevant to coronary heart disease; more recently obesity per se has been identified as a key problem, as has lack of exercise.

3.3.14 Cultural influences mean that very specific and targeted health promotion activity is essential to address lifestyle issues in these groups

Service use

3.3.15 The concept of equity of access to care has been recognised in the national performance frameworks for the Health Service. In relation to ethnic minorities, the

key question is whether the uptake of services for specific ethnic groups is higher or lower than would be expected, given known differences and similarities in the prevalence of particular health problems.

3.3.16 Differences in access may arise in primary care (though studies suggest that minority ethnic communities are not less likely to see their GP), referral to hospital or community health services, or in treatment once referred. Some examples of ethnic differences that have been observed include:

- out-patient attendance rates are lower for some ethnic minority groups
- there is some evidence of inequity in specialist cardiac investigation services, especially for South Asian groups where morbidity is around 40% higher
- high inpatient admission rates of schizophrenia but lower consultation rates in African Caribbean men; and detention rates higher
- lower rates of GP consultation for mental health problems amongst South Asians.

3.3.17 One major barrier to access for some groups, and particularly for their first generation migrants, is language difference. Interpreting services are needed to overcome this.

3.3.18 Again for some groups, cultural differences in the perception of ill-health, and lack of knowledge about the availability and range of health services, can inhibit or delay their access to care until conditions become more serious: here outreach services and advocacy may be cost-effective.

3.3.19 In care settings, acknowledging religious and cultural difference through, for example, accommodation, food and modes of address, is essential if minority groups are to make full use of them.

Health outcomes

3.3.20 The measurement of differences in health outcome should be a fundamental part of any system for looking at inequality. One of the problems is the routine information available on health status itself is pretty limited and often mortality rates have to be used as an indicator of community health status.

3.3.21 For ethnic monitoring, analysis of mortality is complicated by the fact that death certificates do not record ethnic group but country of birth. This creates two problems:

1. The denominator information on country of birth is collected only at the census. If updated information is required, then assumptions have to be made about the population change by country of birth for inter-censal years.

2. The relationship between ethnicity and country of birth is not necessarily simple. For example, many people born in East Africa would classify themselves in a

South Asian ethnic group. Analysis by country of birth will also not pick up people in Black and ethnic minority groups born in the UK.

3.3.22 Differences in perinatal mortality have also been demonstrated on a national basis. Again country of birth (of the mother) is the only available indicator of ethnicity.

Perinatal mortality by mother's country of birth 1989-91, England & Wales

	Perinatal mortality	**Neonatal mortality**	**Post-neonatal mortality**
UK	7.9	4.4	3.2
East Africa	10	5.1	2.3
Bangladesh	10.9	3.8	2.3
India	9.9	5.9	2.7
Rest of Africa	13.2	7.6	3.5
Caribbean	13.3	7.5	4.3
Pakistan	14.2	7.4	5.5

3.3.23 Such analyses are only the starting point. One area for research is the health effects of the second generation, i.e. the sons and daughters of people who moved to the UK. For example, research (1996) has shown that mortality rates amongst second generation Irish migrants are higher than would be expected.

3.3.24 The question of the strength of association between ethnicity and health both over time and in succeeding generations is an important area for further research.

3.4 Health of Refugees and Asylum Seekers

3.4.1 The overwhelming majority of refugees who come to the UK live in London - around 85%. It has been estimated that between 240,000-280,000 people have been through the process of applying for asylum in the last 15 years.

3.4.2 There has been limited research on the health needs of refugees and on the effectiveness of refugee-specific services. However, there is agreement that:

- many of the health problems of refugees are not specific to their status but overlap with health problems of deprived or excluded groups, ethnic minorities or new entrants to the country
- the few health need analyses from London suggest that the average physical health status of refugees on arrival in not especially poor. Most refugees are young and physically fit. There is some evidence to suggest that the health status of new entrants may become relatively worse in the two-three years after entry to the UK.

3.4.3 Although the average measures of health status are reasonably good, there are a significant number of refugees who have health problems characteristic of refugees:

- physical after-effects of war, torture, displacement and journey to the UK
- communicable diseases, the most important of which is tuberculosis
- mental health problems following trauma, and social and psychological problems arising from coping with a new culture, separation from family, loss of status, etc.

4 THE POLICY AND ORGANISATIONAL CONTEXT

4.1 Introduction

4.1.1 Since the adoption of the FUD Strategy in 1998, a number of policy and organisational changes have arisen which affect the policy and organisational context for equalities work in the NHS. The main ones have been:

- NHS Plan
- Shifting the Balance of Power
- patient and public involvement
- Race Relations (Amendment) Act 2000
- Local Strategic Partnerships
- local authority scrutiny of health services.

4.2 NHS Plan

4.2.1 The overarching policy document governing developments in the NHS is the NHS Plan. This sets out the main targets and objectives for the whole of the NHS. Key associated and subsidiary documents are the National Service Frameworks which set out standards for treatment and care in specific areas. In addition, 'Our Healthier Nation' sets out the principle targets for health promotion (cancer, coronary heart disease, accidents, mental health) and identifies the core issue of health inequalities and the need to understand and tackle these.

4.2.2 The principles set out in these policy documents have then been made more concrete with a series of implementation plans. The overall NHS Plan has a series of annual priorities and targets. For 2001-2, there were a number of 'core' targets which underpinned other action; these included reducing health inequalities. The specific targets were primarily concerned with reducing waiting times which includes faster access to primary care and disseminating best practice in the care and treatment of cancer and coronary heart disease.

4.2.3 For 2002-03, health priorities continue to include reducing waiting times and improving emergency services and include implementing the National Service Frameworks (NSF) and national plans for cancer, coronary heart disease, mental health and services for older people. There is also a target to increase the representation of minority ethnic communities at board level throughout the NHS.

4.2.4 In November 2001, consultation closed on a draft implementation plan for health inequalities. In very broad terms, health inequalities are reflected in the differing life expectancies of people living in different places. For the Government, these health inequalities are linked to lower educational attainment, material disadvantage and insecure or no employment. Although no explicit link is made between general health inequality and ethnicity, an implicit link can be made between ethnicity and the incidence of greater levels of deprivation and therefore health inequalities.

4.2.5 The Government expects that strong links will be made between the health inequality agenda with work on developing Local Strategic Partnerships and the community planning process. The implementation plan urges health bodies to ensure that health inequality issues are 'at the core of neighbourhood renewal strategies'.

4.2.6 The format of individual NSFs vary but most begin by identifying the populations at most risk of developing the condition in question. Thus, the Coronary Heart Disease and Diabetes NSF identify certain ethnic groups as being at higher risk. The Mental Health NSF makes reference to the specific needs of people from minority ethnic groups.

4.2.7 The purpose of these NSFs is to ensure consistent provision across the country of high quality evidence based care and treatment with the aim of significantly reducing mortality from these conditions. Ensuring that patients at high risk receive appropriate care is clearly central to this approach.

4.2.8 Although the reduction of health inequalities is a key policy objective for the NHS, there is relatively little in national policy statements and implementation plans which requires health authorities or primary care trusts to look at minority ethnic issues as such. The requirement is implicit in the sense that, in areas with relatively high levels of minority ethnic residents, national targets for the reduction in mortality from specific conditions or the reduction in health inequalities will only be achieved by addressing the needs of these groups.

4.2.9 It is for this reason that considerable emphasis is placed on the role of health improvement programmes (HimP) in driving the strategies forward locally. The HimP is the overarching local health plan and sets out how the national priorities within the NHS Plan, the Health of the Nation, Tackling Health Inequalities and the NSFs will be taken forward at a local level.

4.2.10 Community Care plans used to be the primary planning tool for joint work between Social Services, Health Authorities and the local voluntary sector. That role has now been taken over by the HimP. The Community Care plan now focuses on describing new developments within services for the groups of service users who are jointly the responsibility of Social Services and the Health Authority – older people, people with mental health needs, people with learning disabilities, people with physical disabilities, those with substance misuses problems and people with HIV/AIDS.

4.2.11 Children are the subject of a separate children's service plan. For most of the groups covered by the Community Care Plan, the Government now requires local authorities and health authorities to produce Joint Investment Plans, explaining how they will use their collective resources to provide the most effective services for these groups.

4.3 Shifting the Balance of Power

4.3.1 The NHS Plan sets out a long term programme for reform and performance improvement in the NHS. Underpinning the cultural changes, the Government set out the structural changes it seeks in order to align responsibilities and capacity at most local levels in 'Shifting the Balance of Power.' The two major organisational changes are the creation of new PCTs, largely by staff transfers from health authorities, primary care groups and community trusts, and the creation of new strategic health authorities, with staff from health authorities and the NHS regional offices.

4.3.2 In the new NHS:

- PCTs will become the lead NHS organisation in assessing need, planning and securing all health services and improving health. They will forge new partnerships with local communities and lead the NHS contribution to joint work with local government and other partners.
- NHS Trusts will continue to provide services, working within delivery agreements with PCTs. Trusts will be expected to devolve greater responsibility to clinical teams and to foster and encourage the growth of clinical networks across NHS organisations. High performing Trusts will earn greater freedoms and autonomy in recognition of their achievement.
- About 30 Strategic Health Authorities will replace the existing 95 Health Authorities. They will step back from service planning and commissioning to lead the strategic development of the local health service and performance manage PCTs and NHS Trusts on the basis of local accountability agreements.
- The Department of Health will change the way it relates to the NHS, focusing on supporting the delivery of the NHS Plan. The Department of Health Regional Offices will be abolished and four new Regional Directors of Health and Social Care will oversee the development of the NHS and provide the link between NHS organisations and the central department. The Modernisation Agency, Leadership Centre and the University of NHS will support the development of frontline staff and services.

4.3.3 Resources will devolve alongside responsibilities. Revenue allocations will be made direct to PCTs rather than the Strategic Health Authorities. PCTs and NHS Trusts will also receive direct capital allocations for the maintenance of their facilities. Strategic Health Authorities will control further capital allocations to lever strategic change and service modernisation.

4.3.4 For Kensington and Chelsea, and Westminster, this will mean the creation of Kensington and Chelsea PCT and Westminster PCT in April 2002, taking over most of the functions of the current Health Authority. Parkside Healthcare and Riverside Community Health Care will also cease to exist and be replaced by the PCTs.

4.3.5 The North West London Strategic Health Authority will cover eight London boroughs:

- Brent
- Ealing
- Hammersmith and Fulham
- Harrow
- Hillingdon
- Hounslow
- Kensington and Chelsea
- Westminster.

4.4 Patient and Public Involvement

4.4.1 A key aspect of the NHS Plan is that patients and the public should be more involved in the NHS as it moves towards a model of increased partnership, with patients and the public having a say in how services are designed, developed and delivered.

4.4.2 Following on from the provisions of the Health and Social Care Act 2001, the Government published 'Involving Patients and the Public in Healthcare: a Discussion Document' in September 2001, setting out its proposals to implement a patient-centred NHS outlined in the NHS Plan.

4.4.3 The main elements proposed are:

- to introduce a Patient Advocacy and Liaison Service (PALS) in every NHS Trust and PCT to provide information and on the spot help by April 2002
- to provide a locally based Independent Complaints Advocacy Service operating to defined core standards
- to introduce Patient Forums every NHS Trust and PCT to bring the patients' perspective to Trust management decision making. Forums will be able to elect one of their members to sit on the Trust board as a non-Executive Director
- to extend local authority Overview and Scrutiny Committees powers to scrutinise local health services and to call NHS managers to account
- to set up the Commission for Patient and Public Involvement in Health, a new national patients' body to set standards and provide training and to monitor the new arrangements.

4.4.4 The Government intends to abolish community health councils in England and the Association of Community Health Councils for England and Wales. The Welsh Assembly and the Scottish Parliament have decided to retain their local health councils.

4.4.5 The Government also intends to introduce annual patient surveys in order to obtain patient feedback which can then be used for monitoring purposes and to improve the quality of services. The intention is that all NHS Trusts and PCTs will carry out local surveys to ask patients and carers for their views on the services they have received. However, for 2002, only acute Trusts are expected to carry out patient surveys. Information will be collected in a nationally consistent way so that Trusts can monitor their performance over time and compare their performance to other Trusts. It will also enable the Department of Health to set new patient experience indicators, which will be used in the next set of Trust Performance Ratings due for publication in Summer 2002. There is an expectation that the survey findings will be included in the new Patient Prospectus to be published by every NHS Trust.

4.4.6 The Government has set up the Commission for Health Improvement (CHI) to assure, monitor and improve patient care by undertaking clinical governance reviews of every NHS organisation every four years on a rolling programme. It defines clinical governance as the system, steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care. This includes a patient centred approach, an accountability for quality, ensuring high standards and safety and improving patient services. The CHI will also investigate service failures, monitor progress towards meeting the recommendations of the National Service Frameworks and the National Institute of Clinical Excellence guidance. It will be able to respond to requests from individuals and organisations who are seriously concerned about the quality of services within an NHS organisation.

4.5 Race Relations (Amendment) Act 2000

4.5.1 The Race Relations (Amendment) Act 2000 extends the obligations under the Race Relations Act 1976. Since April 2001, public services have been under a legal obligation to outlaw racial discrimination in all functions and have a general duty to promote race equality. This duty means that public bodies (including voluntary and private sector bodies who carry out public functions) must have due regard to the need to:

- eliminate unlawful discrimination
- promote equality of opportunity and
- promote good race relations between people of different racial groups.

4.5.2 These general legal duties have been supplemented with specific duties which need to be carried out by certain public bodies. In the NHS, these named bodies are health authorities, special health authorities, NHS trusts and primary care trusts. As

soon as they are set up, strategic health authorities and care trusts will be added to the list of named bodies.

4.5.3 The general duty came into force on 2 April 2001 and specific duties on 3 December 2001. NHS Trusts and PCTs are required to produce a Race Equality Scheme and a plan for collecting and publishing a range of specific data relating to employment by 31 May 2002.

4.5.4 To help public authorities comply, the Commission for Racial Equality has provided statutory codes of practice on implementing the legislation. These are currently out to consultation until 28 February 2002. The codes of practice are very comprehensive and set out what is to be done with examples of how it might be done.

Race Equality Schemes

4.5.5 NHS Trusts and PCTs have a specific duty to prepare and publish a Race Equality Scheme, to be reviewed at least every three years, which sets out how they plan to meet the general and specific duties. A Scheme should:

- identify which functions and policies are relevant to the duty
- assess and consult on the likely impact of these functions and policies
- consider and make changes to functions and policies in order to meet the duty
- monitor policies for adverse impact
- publish any results from the above analysis
- ensure the public have access to information and services they provide
- train staff in connection with the general and specific duties.

4.5.6 To decide which functions and policies are relevant to the duty, it would be helpful to ask:

- is it relevant to the general duty?
- which of the three aspects of the duty does it relate to (if any or all)?
- is there evidence that some racial groups could be differently affected?
- what is the degree of relevance?
- how much evidence is available?
- is there any public concern that the function/policy is being operated in a discriminatory manner?

4.5.7 To monitor policies for any adverse impact, it would be helpful to:

- monitor the effect on different racial groups
- check whether there are any differences between racial groups
- assess whether these difference have an adverse impact on a particular group.

4.5.8 This assessment will require authorities to use available research e.g. statistics, research and survey findings, ethnic monitoring data, benchmarking with other authorities' policies

Employment

4.5.9 The employment duty requires public authorities to conduct ethnic monitoring for all staff in post, all applications and (for authorities employing over 150 or more full-time equivalent staff) to monitor those who receive training, benefit from performance assessment, are involved in grievance and disciplinary procedures, and cease employment. Furthermore they must analyse these statistics to find patterns of inequality and take action to remove any barriers. The results of this exercise must published annually.

Liability

4.5.10 Public authorities are responsible for meeting their general and specific duties. Within each public authority this responsibility will rest with the groups or individuals who are liable for the authority's acts or omissions.

Voluntary or private organisations carrying out a public authority's functions

4.5.11 When a public authority has a contract or other arrangement (such as a grant) with a private or voluntary organisation to carry out any of its functions that are relevant to its duty to promote race equality, the authority will need to consider whether the current arrangement meets the general and specific duties. This means that Trusts, in their commissioning role, must demonstrate that their contractors or grant aided organisations also promote race equality.

Partnership

4.5.12 Public authorities acting in a partnership are still responsible for meeting their general and specific duties under the Act. In practice, this means that a public authority working in a mixed partnership which includes organisations who have no statutory duties under the Act must be satisfied that the arrangements for planning and managing joint work will meet its statutory duties.

Inspection and audit

4.5.13 Agencies that audit or inspect public authorities are bound by the duty to promote race equality. These agencies will need to consider how the new duty fits with their inspection or audit obligations.

Enforcement

4.5.14 The Race Relations (Amendment) Act 2000 gives individuals the right to take legal action against unlawful discrimination. The Act also gives the Commission for Racial Equality (CRE) the power to take legal action against certain acts of unlawful discrimination. The CRE has a new power under the amended Act to enforce the

general and specific duties to promote race equality. If a public authority does not meet its general duty, its actions (or failure to act) can be challenged by an application to the High Court for judicial review. An application for judicial review can be made by a person or group of people with an interest in the matter, or by the CRE.

4.5.15 As to the specific duties a public authority that does not meet them could face enforcement action by the CRE. The CRE can serve a compliance notice on that authority which will state that the authority must meet its duties and tell the CRE within 28 days what it has done, or is doing, to meet its duties.

4.6 Local Strategic Partnerships

4.6.1 The Local Government Act 2000 introduced a programme of reform to strengthen the links between councils and local people. As a result, both Kensington and Chelsea Council and the City of Westminster Council replaced their system of governance through committees with a new leader and cabinet structure in 2001.

4.6.2 The Act also requires:

- councils to join with others to form a Local Strategic Partnership (LSP) by February 2002
- LSPs to prepare a Community Strategy by April 2002
- and agree a Neighbourhood Renewal Strategy.

4.6.3 A LSP is a single body which will provide an overarching framework within which specific partnerships operate. It will serve to join together organisations to tackle the issues that matter most to local people, such as crime, education, jobs, health and housing.

4.6.4 The Government expects that every local authority area should be covered by an LSP that brings together the public, private, business, voluntary and community sectors to identify the top priorities of the community and to work with local people to address them. The Government has not specified the geographical boundaries of LSPs, but encourages the involvement of a combination of local, sub-regional and regional organisations.

4.6.5 Some partnerships will focus on single themes whilst others will deal with cross-cutting issues, e.g. drug use involves organisations from a number of sectors: housing, social care, community safety and health. LSPs are intended to co-ordinate, rather than duplicate, existing strategies and plans. They are intended to link strategic decision making with local priorities. The intention is that this will lead to:

- greater co-ordination of existing activity
- more effective use of time and resources

- greater understanding of how partners work
- a more integrated approach to service delivery
- a higher profile for regeneration initiatives
- a clearer focus for partnerships though a shared vision and a strategic framework
- all partners focussing on outcomes and how mainstream funding can be used to achieve them.

Community Strategy

4.6.6 One of the main responsibilities of the LSP will be to produce and implement a Community Strategy for promoting or improving the economic, social and environmental well-being of the area.

4.6.7 A Community Strategy will provide the long-term vision and co-ordination of the actions of the public agencies and private and community organisations to meet the needs and priorities of local communities. The Strategy will look forward 10-15 years and make plans to enhance the quality of life of local communities. It should contribute to the achievement of sustainable development in the UK through action to improve the economic, social and environmental well-being of the area and its inhabitants.

4.6.8 The Community Strategy will not replace existing strategies and plans but will look further ahead and seek to ensure a consistent approach between the various plans. Any individual strategy can have wider implications beyond its traditional professional boundaries. For example, the Health Improvement Programme covers not only health matters but also reflects upon related community safety and environmental issues.

4.6.9 By considering the long term implications of pursuing current approaches, the Community Strategy encourages agencies to plan and work together to achieve better outcomes for the community.

Neighbourhood Renewal Strategy

4.6.10 Closely linked to the Community Strategy, will be the Neighbourhood Renewal Strategy. This forms part of the Government's vision that within 10-20 years no-one should be seriously disadvantaged by where they live. The Government's long term aim for Neighbourhood Renewal centres on agreeing common goals for measures such as lower unemployment and crime, in the poorest neighbourhoods, and narrowing the gap on these measures between the most deprived neighbourhoods and the rest of the country.

4.6.11 The LSP will also be required to agree a Neighbourhood Renewal Strategy in order to claim Government funding which is aimed at narrowing the gap between the most deprived neighbourhoods and the rest of the country.

4.7 Local Authority Scrutiny of Health Services

4.7.1 The Local Government Act 2000 requires all councils to introduce at least one 'Overview and Scrutiny Committee' to hold to account those responsible for the council's decisions and to review its work and operation. The Act also gives these

committee a power to ‘make reports or recommendations... on matters which affect the authority’s area or the inhabitants of that area’.

4.7.2 The Health and Social Care Act 2001 extends this power to ‘review and scrutinise... matters relating to the health service’ and ‘to make reports and recommendations on such matters in accordance with the Regulations’. This new duty will be brought into effect in 2002 and guidance issued on the scope of this duty.

4.7.3 The new health scrutiny arrangements will include a requirement for the chief executives of NHS Trusts and PCTs to attend the local authority scrutiny committee at least twice annually if requested. Councils will also be able to refer contested service changes to a new Independent Reconfiguration Panel.

5 EVALUATION METHODOLOGY

5.1 Introduction

5.1 As the Health Authority and its partners had been implementing the Strategy since 1998, the Health Authority's FUD Strategy Group asked BME Health Forum to co-ordinate an independent evaluation of the Strategy. The Forum set up a Task Group to oversee this work. Zahno Rao Associates were commissioned to undertake the evaluation in November 2000.

5.2 The Evaluation Brief

5.2.1 A number of issues have arisen since the Strategy was developed:

- the Stephen Lawrence Report and the resulting Race Relations (Amendment) Act 2000
- the restructuring of the NHS with the creation of strategic health authorities and primary care trusts to be in place by April 2002.

5.2.2 The evaluation objectives were defined as:

- to review the Strategy and the extent to which commissioners and providers have taken the Strategy's set of principles on board in their work, including the effectiveness of:
    - ◊ information systems on Black and ethnic minority communities and health needs
    - ◊ commissioning for the health needs of minority communities
    - ◊ joint working with statutory and non-statutory agencies on health and equalities
    - ◊ accessibility and appropriateness of health services for minority communities
    - ◊ user involvement and participation
    - ◊ workforce policies and procedures to combat discrimination and provide accessible and appropriate services
- to review how the Strategy can be built on in the light of subsequent policy developments (NHS Plan, Stephen Lawrence Report, Race Relations Amendment Act) and organisational changes (the new strategic health authority and primary care Trust structures)
- to make recommendations on:
    - ◊ how the needs of minority communities can be met within the NHS Plan

◊ commissioning and performance management
◊ how services can meet the changing needs of a changing local population
◊ identifying and spreading best practice in health and equalities
◊ user involvement and consultation.

5.3 Our Approach

5.3.1 It was agreed with the BME Health Forum that the evaluation should be based on semi-structured interviews with the individuals responsible for implementing the Strategy from the key stakeholder organisations, and from key community and voluntary groups. The timetable for this evaluation did not allow for in-depth consultation with BME communities and community groups on their views of the Strategy and its impact on service planning and delivery.

5.3.2 A list of the individuals interviewed can be found in Appendix 1, page 77. The organisations involved were:

- Kensington & Chelsea and Westminster Health Authority

PCGs

- Kensington and Chelsea Primary Care Group
- Westminster Primary Care Group

Health providers

- Chelsea & Westminster Healthcare NHS Trust
- St Mary's Hospital NHS Trust
- Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust
- Parkside Healthcare NHS Trust
- Riverside Community Health Care NHS Trust
- Kensington & Chelsea and Westminster Community Health Council

Local authorities

- City of Westminster
- Royal Borough of Kensington and Chelsea

Voluntary organisations

- Chelsea Social Council
- Notting Hill Social Council
- Migrant and Refugee Communities Forum
- Voluntary Action Westminster
- BME Health Forum
- Somali Welfare Association.

5.3.3 This evaluation was carried out between December 2001-March 2002. An interview was sought with a representative of the Westminster Race Equality Council during this period but it was unable to provide a contact.

5.4 The Evaluation

5.4.1 The interviews sought to assess the impact on commissioning and service delivery of the Strategy's five principles of commissioning for an ethnically diverse population. These principles covered:

1. Information
2. Needs
3. Access
4. Appropriateness
5. Variations.

5.4.2 The broad areas we planned to cover during the interviews were:

Information

- evaluate the progress in setting up a central information resource on the Black and minority ethnic population of Kensington and Chelsea, and Westminster; whether the systems can provide the information originally envisaged, i.e. size, location, languages spoken, religious denomination, age profile, community contact points, data on refugees and asylum seekers; the difficulties encountered; how data is stored, updated, shared with local partners and used.

Needs

- evaluate the Health Authority's understanding of local minority communities health and social circumstances; assess the impact at local level of national studies of the propensity of particular ethnic groups to experience particular health issues and identify whether research has been undertaken and what knowledge is available about; analyse whether service reviews and analyses of health and ethnicity address the needs of the Black and ethnic minority population; identify the priority ethnic minority health issues have within the health inequalities agenda locally.

Access

- identify any research done to determine what makes it difficult for ethnic minority communities to access health services or find appropriate services; review strategies and work to improve access to health services for the Black and minority ethnic population covering written materials, interpretation and staff training; identify current issues and gaps in services, particularly whether ethnic minority patients spend longer on waiting lists; identify good practice in delivering services to the Black and minority ethnic population; review the effectiveness of community links between providers and the Black and minority ethnic population.

Appropriateness

- analyse the extent to which Health Authority's audit of Trusts' current performance has identified the appropriateness of services for ethnic minority users and on specific minority health issues; identify any gaps and good practice and the extent to which good practice been mainstreamed or incorporated more

widely into practice; assess the support given to ethnic minority GPs and whether there are gaps in appropriate GP services; identify the anti-discriminatory policies and practices of GPs and Trusts and how they have been implemented in practice.

Variations

- assess the effectiveness of the Health Authority's links with minority communities and the extent of their involvement in service planning and delivery.

Local initiatives

- identify local initiatives set up to meet the needs of ethnic minority communities and whether the Strategy's criteria were used.

6 THE EVALUATION

6.1 Introduction

6.1.1 In this section, we report on our findings based on the interviews and information collected during this evaluation. Our aim has been to draw out key themes and issues, relating to the past three years of the Strategy and to the future.

6.1.2 We have grouped our findings under the five main Strategy areas rather than report by individual or organisation. Finally, we report on how the Trusts and PCGs have developed their own FUD strategies and action plans, and the involvement of the two local authorities.

6.2 Information on BME Communities

FUD Objective

1. Put into place an information system designed to provide an accurate assessment of the numbers and geographical distribution of the ethnic minority communities living in Kensington and Chelsea, and Westminster.

Evaluation Criteria

- There is a central information resource on the Black and minority ethnic population of Kensington and Chelsea, and Westminster which can provide the information originally envisaged, i.e. size, location, languages spoken, religious denomination, age profile, community contact points, data on refugees and asylum seekers.

6.2.1 The **Health Authority**, in collaboration with the four Trusts and the Social Services Departments of Kensington and Chelsea, and the City of Westminster, set up the Social Mapping Project to provide better information on the minority ethnic groups in the Authority's area. The Project aimed to aggregate monitoring data from a wide range of statutory and voluntary sources from within and outside the health sector.

6.2.2 The Authority's Public Health Intelligence and Evaluation Unit published a report on the Project in September 2001. It found that:

- the database contains 188,429 records – approximately 50% of 1999 population for KCW. The small number of records reflects the capture of only

those people currently in contact with services and the level of ethnic monitoring by the organisations involved.

- the database structure allows data to be viewed by ethnic group, age band and sex at PCG level, borough, locality and ward level
- aggregation of a wide range of data sources was problematic. Due to the lack of a unique record identifier, a 'fuzzy matching' process was used to avoid duplicate records (based on date of birth, ethnicity and postcode). This method incorrectly deletes twins and multiple births as well as double counting people that may have erroneously been recorded with different ethnicities by different agencies. It is also unlikely to develop a full population register.
- there was inconsistency in the ethnic codes used by the different agencies. The project used the 1991 Census expanded list as recommended by the Commission for Racial Equality – 'hand sorting' was needed to standardise the codes from different agencies.
- 30,000 records were discarded due to duplicates and lack of data
- the data is at least one year old. The intention was to collect data every six months even after the project finished so that the data set could 'grow'. Unfortunately this did not happen.
- the current data quality is poor – one respondent pointed out that there were 'only three Moroccans registered in the database but hundreds are known to be resident in KCW'.

6.2.3 The report found that principally due to the incompleteness of the data, the data from the Social Mapping Project has not been used.

6.2.4 The report noted that the Project was an ambitious project and that the generally poor quality of ethnic monitoring within KCW as well as differences between ethnic categories presented considerable challenges to the success of the project.

6.2.5 The report concluded that several important lessons can be learned from the Project:

- BME data is important for informing appropriate public health action
- there is demand for such data
- current knowledge of BME groups is poor
- current monitoring can be improved
- data is needed to support interventions and actions
- collecting data alone is not enough to motivate interventions and actions
- cross sector collaboration is necessary and fruitful.

6.2.6 The report recommends that the Project is discontinued because of the considerable challenges faced by the strategy employed by the Social Mapping Project, the poor quality of the data currently collected and the lack of robustness of the database.

6.2.7 KCW's Public Health Intelligence and Evaluation Unit has utilised other sources of data on the BME communities, such as in-patient monitoring, NHS data, Census 1991 data, London Research Centre data, etc, to provide information on the health

of local BME communities. However, this data does not provide the detailed information on BME communities envisaged by the Social Mapping Project.

6.2.8 There were differences in opinion as to the usefulness of such an approach, with the contention that such database projects cannot succeed because of the lack of meaningful ethnic data. However, there is a belief that a more comprehensive picture of BME groups can be achieved at the primary care level by the PCTs.

Key Points

1. The Social Mapping Project was a very ambitious project but it did not achieve its objective.

2. The Project did show that many organisations collect BME data. However, if such a database is to be developed in future, there is a need for the organisations involved to agree an effective methodology to improve data collection, aggregation and utilisation.

3. There are differences in opinion as to whether the approach adopted by the Project of a 'database of databases' was the right one or necessary, given the alternative datasets available.

4. However, the need to have information systems which can provide an accurate assessment of the numbers and geographical distribution of the ethnic minority communities living in Kensington and Chelsea, and Westminster is still recognised.

5. The requirements of the Race Relations (Amendment) Act 2000 will mean that sustainable mechanisms for obtaining reliable data on the BME communities need to be in place. In order to learn from the experience of the Social Mapping Project, the stakeholders should re-agree what data is needed, how this can best be obtained, aggregated and used to plan and monitor health services.

6.3 Health Needs of BME Communities

FUD Objective

1. Improved understanding of local minority communities health and social circumstances and assessment of health variations associated with ethnicity.
2. Ability to use national studies of ethnic health issues at a local level to establish if there is a problem locally and to develop local solutions.
3. Service reviews and analyses of health and ethnicity address the needs of the Black and ethnic minority population.

Evaluation Criteria

- The Health Authority has an understanding of local minority communities health and social circumstances and health variations associated with ethnicity.
- National studies of the propensity of particular ethnic groups to experience particular health issues are related to the local level.
- Service reviews and analyses of health and disease address the needs of the Black and ethnic minority population.
- Ethnic minority health issues are included in the local health inequalities agenda.

6.3.1 In the absence of data from the Social Mapping Project, the **Health Authority Public Health Intelligence and Evaluation Unit** (set up in June 2001) has used a variety of other data to provide information on the BME communities.

6.3.2 For example, the ONS 1991 Census data and the projections of ethnic groups for London boroughs provided by the Data Management and Analysis section of the Greater London Authority (formerly the London Research Centre). This has provided a population base from which national prevalence and incidence data may be applied. The Annual Health Report 2001 utilised data on the languages spoken in schools to illustrate the ethnic diversity in the two boroughs.

6.3.3 The Health of Londoners Project produced two reports that have proved to be very useful: 'Developing Health Assessment for Black and Minority Ethnic Groups' and 'Health of Ethnic Minority Elders in London.' Arising from the first report was an estimate of the level of risk heart disease by ethnic group. This was incorporated in a sector wide estimate of the demand for revascularisation.

6.3.4 The report by the King's Fund 'Improving the Health of Black and Minority Ethnic Groups' was also used as a source in the Annual Health Report 2001. The ethnic boost sample in the Health Survey for England 1999 also provides potentially useful source material.

6.3.5 The Unit has tried to use hospital episode data to examine ethnicity. Other data collection such as the smoking cessation clinic data will record the ethnicity of the client. Mortality data contains country of birth, which divorces it from any population denominator other than the Census ones and so is not that useful.

6.3.6 In common with other health authorities, KCW has adopted the approach of using estimated populations together with estimates of incidence for service planning purposes in areas such as renal services, people with learning disabilities and cardiac services. London is fortunate in having population projections by age and ethnic group, which is not the case elsewhere.

6.3.7 In 2001, the Unit carried out an analysis of waiting times for elective admissions by ethnicity at St Mary's Hospital between 1 April 2000-31 March 2001. Previous analysis had suggested that non-White patients waited longer than White patients.

6.3.8 The report found that 25.7% of patients admitted during the study period did not have their ethnicity recorded. It appears that waiting times for all ethnic groups were significantly less compared to the White group in the Cardiology speciality and for Coronary Arteriography. This could not be explained by confounding factors (age, sex, urgency, distance), patient deferments or clinical need.

6.3.9 Outside of Cardiology, there were statistically significant differences in the geometric mean waiting times for ethnic groups compared to the White group at both speciality and procedure level. However, at speciality level, these differences were often only in one ethnic group and at the procedure level, tended to be small and non-systematic.

6.3.10 KCW's Research and Development Department has carried out recent (as yet unpublished) research in conjunction with other collaborators, as part of the ongoing ACRE study which looked at ethnic differences in the management of coronary disease.

6.3.11 The Census categories (1991 and 2001 categories) tend to form the standard unit of analysis. This does fail to distinguish sub groups and communities, for example ethic minority groups which may be 'hidden' present in the White group such as Turkish or Cypriot communities (and Irish in 1991) or by grouping all Asian groups together. It can also make analysis less useful at a local level where gender, language and religion as well as ethnicity may be of more value and have more meaning.

6.3.12 The **KCW Health Improvement Programme 2001-04** gives a brief analysis of the local minority ethnic population's characteristics and their health needs. The FUD Strategy is referred to in Chapter 3, Reducing Health Inequalities, which considers the needs of the Black and minority ethnic population. This section notes the efforts made by both boroughs to record the ethnicity of people. This has led to new services to address unmet need, e.g. in Kensington and Chelsea, the Pepper Pot Club for older Black people and the African and Caribbean Mental Health Resource Centre.

6.3.13 In Chapter 5, Priority Groups, there is reference in all the sub-sections, except teenage pregnancy, learning disabilities and physical disabilities, that Black and minority ethnic residents may have specific needs. All the action plans, whether dealing with the whole area or one or other borough, identify some specific initiative. In some cases, for example, older people in Kensington and Chelsea, these initiatives involve the development of a new strategy for working with Black and minority ethnic users.

6.3.14 Chapter 6, Clinical Priorities, sets out how the national clinical priorities make relatively few references to the needs of Black and minority ethnic residents. The table giving actions to address the NHS Plan national targets has only one reference to BME issues – the need for ethnic monitoring.

6.3.15 Chapter 7.3 gives information about the priorities of the PCTs. All make mention of the importance of looking at the needs of Black and minority ethnic patients in some contexts and two of the current PCGs make specific reference to implementing their own Facing Up to Difference Strategy. The work highlighted tends to be services for refugees and asylum seekers than the settled Black and minority ethnic residents.

6.3.16 The Health Authority's **Annual Public Health Report 2001** covers the three most significant issues for the Authority: health inequalities, refugees and asylum seekers and housing. The Report notes that over the last decade, health inequalities have widened. Life expectancy is higher in the Authority's area than in any other in England but the difference between the ten most deprived and the nine least deprived wards was greater than the equivalent difference across London as a whole. No explicit link is made between general health inequality and ethnicity apart from the Chapter 5, Refugees and Asylum Seekers. However, research has consistently supported the contention that an implicit link can be made between ethnicity and the incidence of greater levels of deprivation and therefore health inequalities.

6.3.17 The **NHS London Regional Office** has set an 80% performance target for the recording of the ethnicity of all NHS in-patient users. The Health Authority and Trusts will publish their performance on ethnic recording and an action plan on using the new set of 16 ethnic categories by March 2002.

6.3.18 The **BME Health Forum** has also been a key mechanism for finding out the needs of BME communities. It was launched in February 2001 after extensive consultation in the two boroughs and currently has over 290 members from health commissioners and providers, statutory agencies, community and voluntary groups from across the Health Authority's area. It holds quarterly meetings and produces a quarterly newsletter.

6.3.19 The Forum is funded by the Health Authority and has two part-time managers. When the Health Authority ceases to exist in April 2002, the Forum will continue in existence covering both boroughs and hosted by Westminster PCT. Funding has been agreed until December 2003.

6.3.20 The BME Health Forum was established to provide a formal mechanism which could give added drive to the efforts across KCW to improve health and reduce inequalities. It builds on the previous work of number of BME community health initiatives and forums. The Forum is an independent policy forum, accountable to an Advisory Group composed of community, voluntary and statutory agencies.

6.3.21 The Forum aims to create an effective and sustainable mechanism for communication between the Health Authority, other NHS bodies and BME community groups and individuals, in order to empower communities to effectively engage in a debate between them and the local health services.

6.3.22 Its key role is to oversee development of the Facing up to Difference Strategy and to ensure health is integrated as an issue for other KCW wide regeneration, neighbourhood renewal and other strategies.

6.3.23 In particular, the Forum aims to:

- develop and drive the Facing up to Difference Strategy, monitoring its implementation and delivery by all relevant stakeholders across KCW
- consider and advise on the health and social care dimensions of key borough based or KCW wide strategies, including regeneration, neighbourhood renewal and community safety programmes and strategies
- promote, endorse and encourage the incorporation of health improvement and reduction in inequalities in the work of individual members of the Forum and community development work
- initiate and manage any programmes of action that further the work of the Forum and aims of the Health Improvement Programme and FUD Strategy.

6.3.24 A key aspect of its working practice is to set up time-limited task groups to take forward issues or initiatives. Task Groups are set up to take forward particular pieces of issue-based, community-based or geographically-based initiatives. They are time limited (3-6 months) and accountable to a Steering Group for the particular Task Group. A key feature of the work of Task Groups is to fund and support community groups to run consultation events with their users in order to provide qualitative feedback on health services to commissioners and providers.

6.3.25 The current Task Groups are:

- *Substance Misuse and Community-Based Work with BME communities and community groups*. There are two aspects to this Task Group:
  - ◊ in Kensington and Chelsea, the PCG are funding an assessment of need in BME and newly-arrived communities relating to drugs and substance-misuse. The aim is to reduce drug use, improve health and a reduction in offending behaviour by members of BME and newly-arrived communities and to facilitate better access to services by residents from these sections of the local community.
  - ◊ in Westminster, the initiative is focusing on providing diversity training for mainstream service providers' staff and on implementing a Community Education/Community Development Initiative on Substance Misuse within BME communities. In addition, a workshop will be held to work towards drawing up a strategy for substance misuse work for the coming year.

- *Arabic-speaking Community Groups in Kensington and Chelsea: Experiences of using Health Services by Muslim Women*. During the year-long consultation that led to the setting-up of the BME Health Forum, the issue of access to health services, particularly hospital services by Muslim women was identified as an issue of concern. This Task Group will be a mini action-research

project whereby local community groups working with Muslim women from different nationalities will be commissioned and funded to run a series of consultations with Muslim women they work with. The focus will be on access issues to primary care, hospital and community health services. Statutory agencies will be invited to participate in these sessions to enable them to link this with other consultation work they may already undertaking. A report and action plan will be produced and recommendations followed up by the BME Health Forum with relevant Trusts and service providers.

- *Education, Under-Achievement and Family Support Issues Affecting Young People from BME communities*. The concern about young people and issues related to under-achievement and family support issues in BME communities was raised at the launch of the Forum by a number of individuals and groups. This Task Group will focus on the health and family support issues related to young people and concerns about education and under-achievement. The aim will be to bring together those currently providing services in this field, as well as community groups and individuals from BME communities to evaluate current service provision and issues related to access to services, information and publicity, needs assessment, etc.

- *HIV and Sexual Health Services for BME communities and community groups*. This Task Group will be a project whereby local community groups working with Black and minority ethnic communities will be commissioned and funded to run a series of consultations with communities they work with. The focus will be on access issues to HIV Treatment and Care Services, HIV Prevention Services as well as Sexual Health Services. The Task Group will look at unmet need, as well as ways of ensuring that services are culturally appropriate for Black and minority ethnic communities. Statutory agencies will be invited to participate in the consultation process, and a report and action plan will be produced and recommendations followed up by the BME Health Forum with relevant Trusts and service providers.

- *Evaluating KCW Health Authority's Facing Up To Difference Strategy*

- *Interpreting Services in health services in KCW – a community perspective:* Silkap Consultants are currently undertaking a review of GRIP services looking at management systems and ways in which the services could be improved. The BME Health Forum is undertaking this separate informal consultation initiative aimed at providing a community perspective on interpreting services provided by GRIP. The BME Health Forum has sought feedback as part of an informal consultation with its members - community groups, GRIP interpreters and commissioners.

6.3.26 **BKCW Mental Health Trust** conducted a Trust-wide ethnic monitoring exercise of data from April-September 2000. The report covered the mental health services provided by the Trust to Brent, Kensington and Chelsea, and Westminster, but not

its substance misuse services or a number of stand-alone information systems in the Trust, i.e. complaints, grievances, serious untoward incidents, accidents and incidents, and disciplinaries.

6.3.27 The report sought to look at workforce composition and inequalities in access and treatment outcomes. The data indicated that there was a high level of ethnic recording in most areas, the apparent fairness of selection procedures and generally low levels of ethnic inequality by comparison with national figures. The report recommended that an action plan be prepared covering the issues raised by the report.

6.3.28 In 2001, a draft Action Plan was developed which is intended to cover the cycle of ethnic monitoring: recording, analysis and review, action planning and implementation. The Plan proposes a wide range of initiatives across its services, including:

- mapping good practice
- improving faith provision
- encouraging GPs to refer BME patients for psychotherapy
- providing Islamic counsellors
- improving the ethnic monitoring of service users
- using ethnic monitoring to inform the planning of services
- providing staff with training on ethnicity and cultural sensitivity.

6.3.29 The two **Health Authority Community Health Development Teams** have a remit to identify health needs as part of their community development role.

6.3.30 Both **Kensington and Chelsea PCG** and **Westminster PCG** have User Involvement Groups which provide a means for residents to be consulted and involved.

6.3.31 There are a number of regeneration projects underway in KCW's area and these have funded work on the health needs of BME communities in their area. For example, the **New Life for Paddington Initiative** funded a research project into the Bangladeshi community in North Paddington. The research found high levels of diabetes, coronary heart disease, walking difficulties, anxiety and stress, and poor dental hygiene.

Key Points

1. Despite the failure of the Social Mapping Project, the Health Authority has been able to obtain a range of data about the health needs of the BME population.

2. The BME Health Forum, through its policy work and Task Groups, has played a significant role in conducting research and providing information about the BME communities and their health needs, as well as developing the engagement of these communities with health commissioners and providers.

3. The Health Improvement Programme refers to the FUD Strategy and recognises that BME residents may have specific health needs. It is also clear that the Health Authority, PCGs, and local authorities have an awareness of the importance of these issues.

4. Overall, action to address the needs of older people from the Black and ethnic minority communities seems most advanced than for any other client group.

5. However, most outputs from the Programme have a timescale of 2001. This is understandable given the imminent organisational changes but does mean that a picture of the longer term direction of health equalities work is not yet available.

6. The national policy framework for addressing the needs of Black and minority ethnic service users in the NHS is not strong. Although considerable emphasis is placed on tackling inequalities, ethnicity has not been explicitly recognised as a factor in this.

6.4 Access to Services

FUD Objective

1. Improve information for patients on how to register with GPs and dentists.
2. Promote wider use of interpreting and translation services.
3. Provide outreach support to refugees and asylum seekers.
4. Identify training needs of front line health care staff and general practice reception staff to provide a culturally sensitive service.
5. Develop links and long-term working relationships with community groups.

Evaluation Criteria

- Targeted initiatives to improve access to services for BME communities.
- Training for front-line staff on the communication needs of BME communities and in cultural awareness.
- Effective community links between providers and BME communities.

Information and language support

6.4.1 The **Health Authority Community Health Development Teams** aims are to promote health improvement, access to services, social inclusion and health equality through:

- community and user involvement in health
- joint work with the voluntary sector and other agencies
- health promotion in the community
- regeneration and healthy living initiatives
- improving access to services.

6.4.2 The Teams have developed an Access to Service Information pack and display, local Access to Health videos, promoted GRIP and funded translation of leaflets, promoted NHS Direct to hard to reach BME communities, as well as undertaking outreach work in the community with minority ethnic groups.

6.4.3 **Kensington and Chelsea PCG** and **Westminster PCG** have undertaken a number of initiatives to help refugees and asylum seekers access primary care services, e.g. Local Development Schemes for GP registration, the work of the Health Support Teams and the Earls Court Project.

6.4.4 **Parkside Healthcare** manages GRIP (Group of Reliable Interpreters in Parkside), which provides face to face interpreting, telephone interpreting, translations and British Sign Language services to all the providers in Kensington and Chelsea, and Westminster apart from Riverside Health Care. A team of over 400 professional interpreters covering over 50 languages provide a pre-planned appointment based service.

6.4.5 The utility of having access to a service such as GRIP was widely commented on. However, there were criticisms of its organisation and management from some Trusts' representatives interviewed for this evaluation. Parkside Healthcare in collaboration with the Health Authority and the Consortium of Commissioners in Brent and Harrow is currently conducting an evaluation of GRIP by Silkap Consultants, who are expected to report shortly.

6.4.6 **Riverside Community Health Care** has recently contracted with Community Interpreting and Translation Access Services (CITAS) to provide interpreting and translation services in over 50 languages.

Services for refugees and asylum seekers

6.4.7 The **Health Authority** has provided or commissioned a number of services:

- Refugee Support Service (from BKCW Mental Health Trust)
- a Refugee Health Advocate Worker based in the Community Health Development Teams

- Local Development Schemes to improve the access and quality of primary care services for refugees and asylum seekers through the PCGs
- agreed funding of £250,000 in 1999 to develop services for refugees and asylum seekers over three years.

6.4.8 **Kensington and Chelsea PCG** provides:

- a bi-lingual Arabic counsellor based as the Scarsdale Medical Centre, providing eight hours a week of talking therapy
- with Threshold Housing Centre, a Health Advice and Information Centre opened in 2001 for refugees and asylum seekers living in the Earls Court area
- outreach service to hotels in Earls Court
- a Local Development Scheme to improve access to primary care for refugees and asylum seekers was set up for GP practices in South Kensington and Chelsea. A Primary Care Facilitator was appointed in April 2000 to support the GP practices registering and providing services. There are proposals to extend this Scheme to North Kensington
- North Kensington Health Support Team
- a planned health support team for South Kensington
- hand held records for refugees and asylum seekers.

6.4.9 **Westminster PGC** has:

- implemented a Local Development Scheme to improve access and the quality of primary care services for refugees, asylum seekers and the homeless
- commissioned health visiting and community nursing by professionals with particular expertise through the Health Support Team
- supported the provision of hand held records for refugees and asylum seekers
- commissioned mother tongue counselling and psychotherapy by professionals with particular expertise through the Refugee Support Service
- promoted the use of GRIP and Language Line
- funded the Bayswater Families Centre.

6.4.10 The **Health Authority** has funded **St Mary's Hospital** and **Parkside Healthcare** to provide a comprehensive trans-cultural TB screening service for new immigrants and refugees on an outreach basis.

6.4.11 **BKCW Mental Health Trust** set up the Refugee Support Service in 2000. It provides a therapy, counselling and support service to refugees and asylum seekers in the North Kensington and North Westminster areas. The service has expanded to cover South Kensington and Chelsea and South Westminster. In 2001, group therapy was provided to Arabic women at the Al-Hasaniya Moroccan Women Centre. A therapy group for Arabic speaking men is also planned.

Staff training

6.4.12 The **Health Authority's** Community Development Teams provides a Anti-Discrimination Training Programme for health staff. The Programme covers the NHS framework for managing diversity, how equalities work is approached at the Health Authority and provider level, the legislative framework and good practice in promoting diversity.

6.4.13 The **Health Authority, Kensington and Chelsea PCG, Westminster PCG, St Mary's, Chelsea & Westminster, BKCW Mental Health Trust, Parkside Healthcare** and **Riverside Community Health Care** provide staff with training on diversity and cultural sensitivity.

6.4.14 Under **Parkside Healthcare's** Institutional Racism Action Plan, recruitment and promotion of BME staff is recognised as a key area for development. In 2001, a workforce report providing ethnicity, gender and disability profiles of applicants indicated significant variations in applications received from BME candidates. Higher success rates occurred amongst White applicants (51%) than BME applicants (8%). These findings are being investigated. Parkside Healthcare also offers a Black and Ethnic Leadership programme to BME staff.

Community links

6.4.15 In 2000, the **Health Authority** conducted a consultation with Black and ethnic minority groups to find out how these communities wished the Health Authority to consult them, on an on-going and interactive basis, about health and health care issues. A Steering Group was set up, two consultation forums held and a questionnaire sent out. Fifty organisations replied. The consultation indicated that the key principles which must govern any new structures were:

- consultation must be on-going and two-way, with clear feedback mechanisms
- the Health Authority must identify adequate funding
- the focus would be on health
- the new structures must be independent and owned by the participants.

6.4.16 In response, the Health Authority supported the establishment of the BME Health Forum in February 2001.

6.4.17 Both **Kensington and Chelsea PCG** and **Westminster PCG** have User Involvement Groups which provide a means for residents to be consulted and involved.

6.4.18 In 1998, the **Health Authority** reported on the results of an advocacy research project 'Another Way to Empower People.' It recommended that the development of local advocacy services should be supported by providing training and development opportunities, particularly for BME communities. The research had

found gaps in the availability of health advocacy services and that there was evidence that refugees and asylum seekers experienced problems in accessing primary care and hospital services.

6.4.19 As a result, the **Migrant and Refugee Communities Forum** has obtained funding from the King's Fund and Westminster PCG for a Health Advocacy Training Scheme to recruit volunteers working in the community to train as health advocates. The intention is to link the trainees with local statutory and voluntary organisations and to create a network which can support service users when they need health care.

6.4.20 The **Somali Welfare Association** has trained 12 volunteers in health advocacy. This project was funded by the Health Authority and the Department of Health through the Health Advocacy Training Scheme.

Key Points

1. There has been a broad range of initiatives to provide information about, and help support BME communities to gain access to, health services. A number of services have addressed the specific needs of asylum seekers and refugees.

2. The services provided by GRIP (and latterly by CITAS for Riverside) has enabled providers to have access to interpreting and translating services. However, there were criticisms of the management of GRIP from some Trusts.

3. The Health Authority and Trusts have provided a broad range of training for their staff on equalities issues.

4. The BME Health Forum has been the formal mechanism set up by the Health Authority to consult and involve the BME communities in the planning and delivery of health services. As such, it has played a key role in developing BME community links with the Health Authority and Trusts.

6.5 Appropriate Services

FUD Objective

1. Audit Trusts' performance for ethnic and cultural appropriateness and for work on specific diseases affecting minority communities.
2. Support for GPs with ethnic minority patients.
3. Assess appropriateness of GP services for minority communities.
4. Work with GPs and Trusts to establish anti-discriminatory policies and practices, support changes in working practice and improve staff skills.

☞ **Evaluation Criteria**

- Work with Trusts to provide appropriate services for BME users.
- Support for ethnic minority GPs and gaps in appropriate GP services for the BME communities identified and responded to.
- GPs and Trusts have anti-discriminatory policies and implement them.

Trusts' performance

6.5.1 The Facing Up to Difference Strategy Group has been the primary means by which the **Health Authority** has monitored Trust performance on equalities. The Authority has required each Trust to develop its own equalities strategy, which they have done. The Health Authority has expressed its desire to see the integration of equalities work into the Trusts' and PGCs' clinical governance work.

6.5.2 **Kensington and Chelsea PCG, Westminster PCG, St Mary's, Chelsea & Westminster, BKCW Mental Health Trust, Parkside Healthcare** and **Riverside Community Health Care** have all developed an equalities strategy and action plan based on Facing Up to Difference.

Work with GPs

6.5.3 **GRIP** provides face to face interpreting, telephone interpreting, translations and British Sign Language services to all GPs in KCW's area. A team of over 400 professional interpreters covering over 50 languages provide a pre-planned appointment based service.

6.5.4 The **Health Authority** has supported **Kensington and Chelsea PCG** and **Westminster PCG** to set up local development schemes to facilitate the permanent registration of new arrivals with GPs.

6.5.5 The **Health Authority** has also provided or commissioned a number of services to support GPs, such as the Community Health Development Teams, the Refugee Support Service and GP practice based link workers, advocates and interpreters.

6.5.6 The **Health Authority** has introduced and is managing a GP Vocational Training Scheme for eight refugee doctors. This initiative is funded by the NHS London Regional Office and Deanery, St Mary's Hospital and Central Middlesex Hospital.

6.5.7 It aims to respond to the recruitment problems of GPs in inner London by training more doctors to become GPs, develop an un-used resource in the local community, i.e. refugee doctors, and meet the health needs of BME communities for GPs who are able to speak their languages and understand their culture.

6.5.8 The Health Authority has also:

- offered financial support for refugee doctors in the form of payment of examination fees for the International English Language Testing System and intensive small group tutorials for doctors who have failed the test marginally
- opened the Health Authority library to local refugee doctors
- set up clinical attachments in local Trusts
- secured ad-hoc Senior House Officer posts.

Improving staff skills

6.5.9 **Kensington and Chelsea PCG, Westminster PCG, St Mary's, Chelsea & Westminster, BKCW Mental Health Trust, Parkside Healthcare** and **Riverside Community Health Care** provide staff with training on diversity and cultural sensitivity.

Key Points

1. The Health Authority has provided or commissioned a range of services to help GPs meet the needs of the BME communities.

2. The Health Authority has responded to the gap in appropriate GP services by securing funding the GP Vocational Training Scheme for eight refugee doctors. The doctors speak a variety of languages and half are women.

3. All the provider Trusts have adopted an equalities policy and action plan based on Facing Up to Difference to help them work towards providing an ethnically and culturally appropriate service to the BME communities.

6.6 Recognising Variations in BME Communities

FUD Objective

1. The Health Authority consolidates and builds on established community links.

Evaluation Criteria

- The Health Authority's links with minority communities are strengthened and developed.

6.6.1 The **BME Health Forum** has been the formal mechanism set up by the Health Authority to consult and involve the BME communities in the planning and delivery of health services. The Forum was set up in 2001 after extensive consultation in the two boroughs. It currently has over 290 members from health commissioners and

providers, statutory agencies, community and voluntary groups. Through the Forum's Task Groups, particular pieces of issue-based, community-based or geographically-based work is undertaken.

6.6.2 The Forum oversees the implementation the Facing Up to Difference Strategy and the recommendations from the Task Groups by attending policy groups and forums, e.g. the Health Authority's Facing Up to Difference Strategy Group, St Mary's Facing Up to Difference and Clinical Governance Group, Neighbourhood and Community Strategic Partnership Groups and the developing new patients' bodies such as Patient Forums, PALS.

Key Points

1. The BME Health Forum has been an effective means by which the BME communities can develop and strengthen their links to the health sector in Kensington and Chelsea, and Westminster. Through participation in the Forum's policy work and Task Groups, the BME communities can provide direct input on their experiences and expectations of health services.

2. The Forum's participation in other policy groups and fora help to ensure that the Facing Up to Difference Strategy is widely disseminated and that other initiatives are aware and take account of BME health issues.

3. The advent of the Race Relations (Amendment) Act 2000 with the requirement that each Trust sets up a Race Equality Scheme will mean that the BME Health Forum will have an important role in involving and consulting with the BME communities on these issues.

6.7 Local Initiatives and Partnership Development

FUD Objective

1. To support local initiatives which addressed the health needs of minority communities based on FUD criteria.

Evaluation Criteria

- Local initiatives are set up to meet the needs of ethnic minority communities using FUD criteria.

6.7.1 The **Health Authority** has funded or commissioned a number of projects to meet the health needs of the BME community based on the FUD principles for local initiatives, for example:

- Community Health Development Teams
- Refugee Health Advocate Worker based in the Community Health Development Team
- Refugee Support Service provided BKCW Mental Health Trust
- Arabic Mental Health Worker based in the Westminster Mental Health Advocacy Service
- Locality Development Schemes to improve access and quality of primary care for refugees and asylum seekers by Kensington and Chelsea PCG and Westminster PCG
- providing interpreting services in primary care
- health advocacy schemes with Migrant and Refugee Communities Forum and the Somali Welfare Association
- Vocational Training Scheme for refugee doctors
- setting up the BME Health Forum and the work of its Task Groups
- voluntary sector capacity building jointly with CEMVO.

6.7.2 In addition to these initiatives, the **Health Authority** provided a Voluntary Sector Small Grants Fund of £200,000 in 2001-02, with maximum grants of £20,000 for small groups to develop health promotion initiatives or events. This has funded:

- Migrant and Refugee Communities Forum Visual Impairment Project - £6,900
- Mental Health Black Users' Forum - £4,640
- Portman House homeless women's project - £11,580
- Migrant Resource Centre - £2,370
- Dutch Pot Dignity at Home project - £15,000
- Westminster Refugee Consortium - £10,000
- Abbey Community Centre - £19,735
- Health and Older Chinese People - £15,000
- Iraqi Community Association self-health project - £17,000
- Forward FGM - £15,400
- Yemeni Community Association - £31,700 (with Westminster Joint Finance)
- Migrant and Refugee Communities Forum Carers' Project - £36,000.

☞ **Key Points**

1. A range of local initiatives to meet the health needs of the BME communities have been set up, consistent with FUD criteria.

6.8 Leadership, Ownership and Accountability

6.8.1 A major objective of the FUD Strategy was to provide leadership on equalities work in the health sector and to engage the commitment of service providers. The intention was that equalities work should involve Trusts as much as the Health Authority, and within organisations, should increasingly become the concern and

area of activity of mainstream staff, rather than only that of designated equalities staff.

6.8.2 The FUD Steering Group, which meets every three months, has played an important role in providing leadership on equalities. The interest and involvement of the Health Authority's Chief Executive, who chairs the Group, has played a significant part in this process. The Group also provides a forum where all the key local stakeholders can meet and be subject to peer accountability.

6.9 Trust FUD Strategies

6.9.1 All the Trusts and PCGs in the Health Authority's area have developed their own FUD strategies and action plans.

6.9.2 **Kensington and Chelsea PCG** has set up a Black and Minority Ethnic Sub-group to develop and monitor its Facing Up to Difference Strategy. Its draft Strategy for 2001-03 proposes:

- a strategic and organisational review for its equalities work
- developing an employment and retention policy
- developing primary care services and improving access to them for BME groups. This will include:
    - ◊ evaluating existing Local Development Schemes for refugees and asylum seekers
    - ◊ providing information in community languages
    - ◊ improve interpreting services
    - ◊ improve access to cytology screening
    - ◊ assess the need for a male circumcision clinic
    - ◊ develop health advocacy
    - ◊ assess the need for culturally specific health promotion material
    - ◊ incorporate culturally sensitive family planning advice training into practice nurse training
    - ◊ promote information exchange and partnership working
    - ◊ take forward TB immunisation in community settings
    - ◊ improve access for residents on travellers' site
- improve mental health services for refugees and asylum seekers. This will include:
    - ◊ developing a local Post Traumatic Stress Disorder Clinic
    - ◊ evaluating the Arabic counselling service
    - ◊ developing support groups to provide emotional support
    - ◊ ensuring that primary care services can deal with urgent requests for mental health assessments because of anxiety related to dispersal
    - ◊ improving prevention and treatment of substance misuse
    - ◊ assessing the need for mental health services for refugee children
    - ◊ investigating the accessibility of mental health services.

- information and training. This will include:
    - ◊ training on mental health assessments for refugees and asylum seekers
    - ◊ training on Race Relations (Amendment) Act 2000
    - ◊ developing information for GPs and service users
    - ◊ cultural awareness and diversity training for staff
- promote partnership working. This will include:
    - ◊ ensuring that equalities work links into developments around VOICE, PALS and Patient Forums
    - ◊ maximising the involvement of communities and their ability to influence decision making at all levels
    - ◊ mapping existing health related projects and services for BME communities and developing strategies for funding, joint working and providing support and training
- develop awareness training on children and families' issues for health visitors and promote parenting in BME communities.

6.9.3 **Westminster PCG** set up a Facing Up to Difference Working Group. Its Draft Facing Up to Difference Workplan for 2002 onwards covers the following areas:

Key Area 1 - Understanding the Needs of our Local Community
Community Needs Assessment
Projects underway
Work with local stakeholders to produce a strategy for on going community needs assessments that will avoid duplication of effort.
Projects proposed
Undertake a community needs assessment to ensure that the PCG has up to the minute information about the local population.
Patient Profiling Incentive Scheme across Westminster practices.
User Involvement
Projects underway
Ensure effective consultation with BME groups regarding PCT application.
Projects proposed
To ensure the PCG/T user involvement strategy includes effective consultation and involvement of BME communities which is reflected through appropriate service delivery.

Key Area 2 - Addressing Particular Needs
Advocacy
Projects underway
Refugee Health Advocacy Project.
Mental Health Advocate for Arabic Speaking Communities.
Projects proposed
To ensure that local advocacy is provided by fully trained professionals.
Antenatal Care

Projects proposed

Community based antenatal clinic specifically targeting BEM communities with links to Sure Start.

Interpreting

Projects underway

Evaluation of GRIP interpreting service through external consultant.

To produce a leaflet promoting the use of formal interpreting services.

Production and distribution of an information pack promoting the use of interpreting services in primary care.

Projects proposed

Pilot of community access interpreting.

Materials in Community Languages

Projects underway

Translation of Practice Leaflet.

Review agreement to ensure equity and consistent approach across the new PCG area.

Projects proposed

Dubbing of the video 'Access to Health' into the seven most prevalent community languages.

Translation of the generic health information leaflet 'Your Health' into the seven most prevalent community languages.

Promoting Health and Primary Prevention

Projects underway

Examples:
- Week Health Fair for Arabic Community at the Regents Park Mosque
- Health Fair targeting the Bangladesh Community in Queens Park
- Walking to Health for the Chinese Community
- Smoking Cessation Support Groups for the Bangladesh and Chinese Communities
- Reviewing health education resources available in community languages
- TB awareness sessions for Refugee and Asylum Seekers

Projects proposed

To develop a Westminster wide primary prevention work programme ensuring health priorities for BME communities are identified and interventions are targeted appropriately

Refugees and Asylum Seekers

Projects underway

Review of former PCGs schemes to improve access to and quality of primary care for refugees and asylum seekers (and homeless people).

Review ease of use of the Hand Held Record before a further print run.

The provision of health visiting and community nursing for the target group by professionals with particular expertise through the Health Support Team.

The provision of mother tongue counselling and psychotherapy by professionals with particular expertise in supporting the target group through the Refugee Support Service.

Refugee Health Advocacy Project.

Projects proposed
Develop a Link Worker Scheme to address the social needs of the target group that impact on their general health and well-being.
Work with Bayswater Families Centre to ensure that the services provided there, and that address the social needs of the target group that impact on their general health and well-being, are sustained.
Community-based TB Service Pilot.

Key Area 3 - Developing Culturally Competent Services
Advocacy and Empowerment
Projects underway
An Advocacy Resource Pack for service providers to raise awareness and quality standard to promote further commissioning and use of advocacy.
Projects proposed
Patient Advocacy Liaison Service (PALS) to support patients, carers and families around problem solving and resolution and improve access to services. Must consider responding to diverse needs.
Independent Advocacy Service Complaints (ICAS). Awaiting Government guidance but must ensure the needs of BME groups are considered.
Clinical Governance
Projects proposed
Ensure that cultural competence is built into clinical governance initiatives and the Performance Assessment Framework.
Harassment
Projects proposed
Review extent to which staff are aware of the Harassment procedure.
Organisational Development
Projects underway
Encourage and support members of minority ethnic groups to apply for non-executive appointments for the PCT.
Projects proposed
Review PCG strategy, policy and procedure in light of requirement to promote race equality.
Meet with the Clinical and Managerial Leads to discuss the implementation of the Facing Up to Difference Strategy in their own working groups.
Develop a three year strategy to be reviewed.
Ensure that all Service Level Agreements explicitly state the need to comply with the Race Relations (Amendment) Act 2000.
Refugees and Asylum Seekers
Projects underway
Lunchtime Learning Programme: training for practice staff to improve awareness of refugee rights and specialist services available.
Staff Ethnic Mix
Projects underway
Practice Staff Survey.
Thank You campaign.

Support refugee health workers trained overseas to register and work locally.

Projects proposed
Phase 2 of Thank You campaign: joint working with Training partnership being considered to build on the work of the Thank You campaign.
Review policy on monitoring recruitment and retention of staff.
Training - Diversity
Projects underway
Roll out the piloted training course for clinicians focusing on FGM.
Lunchtime Learning Programme: training for practice staff to improve awareness of refugee rights and specialist services available.
Projects proposed
Anti Discrimination Training.
Consider those conditions that are commonly associated with particular groups, such as Sickle Cell to identify current activity, knowledge of services available among users and practitioners.

Key Area 4 - Addressing Discriminatory Practice
Access to Secondary Care
Projects proposed
Exploration of the issues around refugee access to secondary health services, e.g. community-based TB Service Pilot.
Harassment (Staff, Patients, Westminster Forum)
Projects underway
Improve and support the recording and reporting of racial harassment in the NHS.
Projects proposed
Westminster Race Equality Council project proposes a model of monitoring racial harassment.
Pilot of Racial Harassment Recording Procedures for primary care.

6.9.4 **St Mary's Hospital** has developed an Equalities Framework which was approved by the Trust Board in September 2001. Two main steering groups have been established to take this work forward. The Equal Opportunities Steering Group (EOG) and the Facing Up To Difference Working Group (FUD). The EOG is chaired by a non-executive Director and reports to the Trust Board. The FUD group is chaired by the Director of Nursing and reports to the Clinical Governance Steering Group, which reports to the Trust Board.

St Mary's Facing Up To Difference Working Group

The Trust has been collaborating with the Health Authority to support the development of their Facing Up to Difference Strategy. The FUD Working Group integrates its programme with the clinical governance strategy and work plan. The focus is on service delivery, minimising health inequalities, promoting equity of access to care for all patients and promoting the Trust as a community hospital.

FUD priorities for 2002-03:

- Implement the recommendations of the Race Relations (Amendment) Act 2000
- Develop the Trust Race Equality Scheme in line with the guidance produced by the Commission for Racial Equality
- Develop and implement a User Involvement Strategy and encourage local people to become involved in the development of services for patients and users
- Develop and implement the Patient Advice and Liaison Service and to ensure that the equalities work links into this development
- Implement the Disability Discrimination Act 1995
- Promote the hospital more widely to the local community
- Review the interpreting service to improve access for patients and staff
- Produce translated material to improve access and provide more information about services
- Improve ethnic monitoring to include ethnicity, language, gender and age of patients
- Develop systems to ensure appropriate services are provided for people with Learning Difficulties, those who are disabled and adult/child protection
- Develop a cultural awareness training programme for staff
- Commence looking in more detail at factors and links related to health inequality between ethnic groups which will include:
    - ◊ determinants of health, e.g. age, sex, gender, income, employment, education, housing, social networks, mobility and migration
    - ◊ prevalence of disease or of behaviour and lifestyle that have differential health risks e.g. diabetes, renal failure, cardiovascular disease, limiting long term illnesses
    - ◊ access to and uptake of services which are of potential benefit
    - ◊ measures of health outcome or health status such as differences in mortality.

Equal Opportunities Steering Group

This group focuses on equality and diversity issues for employees, seeking to ensure that the Trust is a fair employer and that it fulfils its responsibility to recruit a workforce that truly represents the local community. There is an overlap between the Vital Connections agenda and work required to achieve The Improving Working Lives Standard and the Recruitment and Retention Strategy. Where this occurs the EOG receives brief reports on the work undertaken by those groups to ensure that the principles of equality, diversity and social inclusion are properly addressed.

Whilst the development of staff is relevant to both sets of priorities, the EOG will take the lead on developing and monitoring the implementation of training initiatives. The programme will be to raise staff awareness about cultural diversity issues, race relations, the health needs of users and the working relationships with colleagues from different ethnic and cultural groups.

Employment from the local community will be the responsibility of the EOG except where there are specific service delivery outcomes to be achieved.

EOG priorities for 2002-03:

- To reduce the incidents of harassment at work. The Trust has an established a volunteer harassment service for confidential staff support. In addition, staff also have access to staff counselling services and the support of line managers, staff side representatives and Human Resources professionals.
- The harassment policy is currently being reviewed to improve the current arrangements for monitoring incidence and outcomes. Data will be used to identify more accurate targets for reduction and highlight any problem areas within the Trust for focused training and intervention.
- Recognise good practice in the recruitment of disabled staff.
- Develop a culturally competent workforce. Equal opportunities, cultural awareness and diversity training are currently integrated into a whole range of training activity within the Trust. In 2002, a 'First at St Mary's' programme for non-clinical staff who are in the frontline of providing services to users was introduced. In 2003, there are plans to undertake a diversity and equalities training needs analysis for all staff groups and, funding permitting, a review of all current training will be commissioned.
- As part of a commitment to regeneration and employment of the local population, St Mary's has been successful in attracting funding for a Basic Skills training needs assessment and will shortly appoint a Basic Skills development post in partnership with Westminster Kingsway College.
- Review the eligibility for Disability 'two ticks' criteria.
- Review the outcomes of the Quality of Working Life Survey and develop an action plan for improvement.
- To ensure compliance to the Race Relations (Amendment) Act 2000 by:
    - ◊ eliminating unlawful racial discrimination
    - ◊ promoting equality of opportunity
    - ◊ promoting good race relations between people of different racial groups.

Achievement of the work programme will help the Trust to move towards its targets which are:

- to develop a workforce that is able to deliver high quality, accessible, responsive and appropriate services, which meet the needs of the diverse local population
- to ensure the Trust is seen as a fair employer achieving equality of opportunity and outcomes in the workplace
- to ensure that the Trust, as an employer makes a difference to the life opportunities of its local community
- to review the application of Equal Opportunities Policies by ethnic monitoring of recruitment, selection and promotion.

Ethnic monitoring of staff at St Mary's

An ethnicity survey of all current staff, who have until now remained on the old ethnicity codes, has been conducted. Approximately 3,000 staff were surveyed in January 2002 and asked to use the census-derived Department of Health ethnicity codes to give their ethnic origin. All new starters since April 2001 have been asked for the new codes. It is planned to use this information to establish a baseline for the ethnic origin of staff by the end of March 2002.

6.9.5 The Board of **Chelsea & Westminster Hospital** in May 2001 approved a paper which proposed the development of a Trust-wide Strategy for the Promotion of Equality and Diversity which will cover both service users and the workforce. An Equalities Taskforce has been established at Board level, chaired by the Trust Chair and the Director of Nursing and Patient Services and Director of Human Resources.

The intention is to set up two groups: a Developing the Service User Perspective Group which will develop user involvement strategies, including improving ethnic coding strategies and engaging patients and their representatives in service development; and a Diversity in Employment Group which will provide an overview of workforce issues from a strategic and operational perspective and will cover recruitment, retention, harassment in the workplace and other workplace issues.

These two groups will support the development of Trust action plans and oversee their delivery.

The strategic framework for promoting equality and diversity has three key themes:

- representation - increasing the representation of minorities in the workforce and service users. For the workforce, this will mean that minority staff and female staff reflect the local community and are distributed at all levels of the organisation. For service users, this will mean ensuring that the views of all parts of the community are incorporated in the Trust's involvement and service development plans.
- harassment - developing clear plans to protect staff from harassment from colleagues and from service users. To date, action has focused on harassment within the workforce but harassment by service users also needs to be confronted to avoid perpetuating an environment which can be perceived as hostile by minority ethnic workers and thereby contribute to their under-representation in the workforce.
- monitoring and target setting - developing a clear data set so that the composition of service users and the workforce can be defined and used to measure targets. A key area of work will be to increase the level of ethnic coding and to ensure that the 2001 Census definitions are introduced throughout the Trust.

6.9.6 The **Royal Brompton and Harefield NHS Trust** established a Diversity Steering Group in May 2000 to oversee the Trust's strategy for equal opportunities issues for staff. The role of the Group is to ensure that the organisation's approach to diversity

and equal opportunities issues incorporates appropriate legislation, NHS guidance and good practice. The Group meets quarterly and is chaired by a non-executive Director and contains a cross-section of staff within the organisation. It reports to the Executive Committee and the Trust Board through the Chair.

The main responsibilities of the Group are:

- to review and merge the Equal Opportunities Policies within the Trust
- to produce a Diversity Policy under which all other policies will be covered
- to monitor and review patient and staff equal opportunities data and ensure that it provides the information required
- to develop organisational ethics and values regarding staff and patient issues
- to review and enhance management practices relating to diversity
- ensure that how the Trust treats staff and patients reflects changes in society and personal expectations
- to ensure that the Trust complies with legislation
- to ensure that the Trust keeps up with best practice in dealing staff and patients
- to make recommendations for the development of a proactive approach for a more representative workforce, using the philosophy of 'Working Together' and 'Positively Diverse'
- to develop training programmes and monitor their effectiveness and delivery
- to raise awareness of Diversity for all staff
- to develop a Diversity Action Plan which encompasses the external and internal agenda
- to provide an annual report to the Trust Board on equal opportunities within the Trust.

There have been a number of achievements in diversity issues since the Group was established:

- the development of a Diversity Policy (approved by the Board in November 2001)
- regular monitoring of workforce information
- gaining the Employment Service Disability Symbol User status, recognising good practice in the recruitment of disabled staff
- Diversity Training undertaken by the Board
- monitoring staff perceptions of diversity within the Trust by the Quality of Working Life Survey.

Diversity remains a key objective for 2002 and the Trust intends to achieve a number of other objectives in the forthcoming year. Actions planned for the next twelve months include:

- diversity training for managers and staff
- introduction of a team of confidential Harassment Advisors for staff
- disability and access audit of Trust premises
- series of Diversity Awareness Days
- promoting employment opportunities to under-represented groups in the Trust
- developing a Diversity Policy addressing patient issues

- developing standard reports on patient diversity
- ensuring information about particular requirements for patients is included in referral letters.

Facing Up to Difference Committee

The Diversity Steering Group agreed in May 2001 to incorporate the Facing Up to Difference Committee's work on patient diversity issues. The Facing Up to Difference Committee had set up three sub-groups to work on three diversity themes:

- access to facilities and services
- religion, culture and ethnicity
- age, gender and culture.

Ethnic monitoring

The Trust regularly monitors diversity information for both patients admitted to the Trust and staff:

- *Patient data*: This is recorded each month and is recorded using the new data set for ethnic origin. The information recorded at Harefield Hospital has less than 2% of patients not stating their ethnic origin. However, there are currently about 16% of patients with invalid ethnic origin codes at the Brompton. This is primarily due to the old ethnic codes not mapping to the new codes easily, which means that patients who have previously been asked for information on their ethnic code need to be asked it again. The proportion of invalid codes has reduced significantly since April 2001 (41% to 16%).
    - ◊ The biggest area of non-compliance at the Brompton are day cases, especially Cardiology, where patients are admitted before Patient Services staff arrive, receive their treatment and are not able to provide this information before they are discharged in the evening.
    - ◊ The Trust intends to compare the ethnic origin of patients seen at both hospitals with the national statistics for the incidence of the condition for which they have been seen. However, initial enquiries have indicated that there may not be appropriate information available to make this comparison.
- *Workforce data*: The Trust monitors the ethnic origin of applicants for vacancies at the Trust and the overall workforce. The analysis of both workforce and recruitment data is complicated by the proportion of 'unknowns' (c.10%) which the Trust will be addressing in 2002.
- The most recent recruitment information available (to 31 March 2001)

indicates that there are a number of areas that the Trust needs to examine in more detail:

- ◊ Admin and Clerical: 23% of applicants for posts are either Black Caribbean, Black African or Black Other, compared to 18% shortlisted and 7% appointed.
- ◊ Medical: 28% of applicants are White, compared to 45% shortlisted applicants and 57% of appointments made. Some of these differences may be explained by the high proportion of 'unknown' returns (due to most medical applications being made by CV rather than application form).
- ◊ Professional and Technical: 25% of applicants for posts are either Black Caribbean, Black African or Black Other, compared to 21% shortlisted and 10% appointed.

- The workforce profile for the Trust's two hospitals indicates that the Trust needs to examine some areas of under-representation in its current workforce:
  - ◊ Royal Brompton: there is a lower proportion of Black Caribbean, Black African or Black Other (11%) staff at the hospital than the population of Inner London would suggest could be expected (17%).
  - ◊ Harefield Hospital: the proportion of Indian, Pakistani and Bangladeshi staff employed at the hospital (4%) is lower than the population of Outer London would suggest could be expected (10%)
- There is no clear reason for the differences described above and the Human Resources Department will monitor these areas during 2002. The Trust will be focussing recruitment advertising of general opportunities in both hospitals during the year to encourage applications from groups that are currently under-represented in the Trust. The Human Resources department will also review which data sets it is appropriate to make comparisons of its workforce statistics (e.g. NHS statistics, local health economy).

6.9.7 The Board of **BKCW Mental Health Trust** has agreed an Equalities and Diversity Statement of Intent and set up a Board Diversity Committee, with borough-based Staff Diversity Groups. There is also a Diversity Partnership Group which includes nominees from service users and community groups. A number of initiatives are undertaken:

- ethnic monitoring
  - ◊ of the recruitment process from shortlist to appointment
  - ◊ the composition of the workforce by grade, area of work and profession, service use by team/locality/in-patient unit, including length of stay, duration of detention, admission route, religion, etc
  - ◊ by complaints, serious untoward incidents and accidents/incidents
- equalities training and development
  - ◊ staff induction programmes include one session on equal opportunities and one on race, culture and diversity
  - ◊ induction training for junior doctors on rotation is planned
  - ◊ a two day equalities foundation module is provided
  - ◊ skills training on cross-cultural communication and assessment is planned

- ◊ tailor-made team development work is offered
- ◊ a disability awareness training programme is available

- targeted clinical services
  - ◊ Asian Families Counselling Service providing own-language counselling for Pakistani, Bangladeshi and Chinese service users
  - ◊ Refugee Support Service providing a therapy, counselling and support service to refugees and asylum seekers in the North Kensington and North Westminster areas
  - ◊ Black User Group and other drop-in services
  - ◊ numerous initiatives within mainstream community health teams
- policy development
  - ◊ a Harassment and Bullying Policy launched in September 2000
  - ◊ draft Equalities Framework launched in October 2000
- miscellaneous
  - ◊ campaign to raise the profile of equalities with posters, through the staff newsletter, year planners with religious festivals included, etc
  - ◊ standing contract with GRIP to provide interpreting services
  - ◊ provision for special needs, e.g. diet, religious observance, toiletries, etc
  - ◊ user of ethnic monitoring in clinical governance
  - ◊ research projects on ethnic issues.

6.9.8 **Parkside Healthcare** set up an Access to Health Group which has concentrated on three priority areas of work:

- developing and implementing an Institutional Racism Action Plan
- ethnic monitoring of service take-up
- addressing the requirements of the Disability Discrimination Act 1995.

Parkside's Institutional Racism Action Plan forms the basis for the Trust's equality and diversity practice and has a number of themes:

- corporate commitment
  - ◊ to establish monitoring and reporting mechanisms to the Trust's Board, raise Access to Health issues at all Directorate meetings and introduce cultural awareness to all staff development reviews
  - ◊ to communicate the Plan to partner service providers and to patients and community groups
  - ◊ to communicate equality standards to contractors and contracted out services
  - ◊ to include a statement of equality commitment in the Annual Report
  - ◊ to increase the awareness of the Plan in the BME media
  - ◊ to achieve the CRE organisational standards
  - ◊ to ensure that capital development projects meet cultural requirements, e.g. usable prayer rooms

- employment
    - ◊ to collect information by ethnic origin, gender and disability on the local population served and applicants for jobs, staff in post and those applying for promotion and training
    - ◊ to review all employment practices
    - ◊ to promote awareness and observance of religious obligations, festivals and spiritual needs
    - ◊ to appoint and train counsellors to address staff harassment and set up a mentoring scheme to support staff experiencing abuse or harassment
    - ◊ to feedback to staff in monthly team meetings corporate decisions and potential implications
    - ◊ to ensure that all staff have staff development reviews
    - ◊ to develop the potential of all staff through mentoring and shadowing schemes, networking and leadership programmes
    - ◊ to ensure that Trust human resources policies are available electronically and extend staff access to them via the intranet
- access to services
    - ◊ to collect information by ethnic origin and gender on the local population served and to achieve 95% ethnic coding of service users
    - ◊ to provide ethnic data on complainants to the Health Authority, PCGs and Community Health Council
    - ◊ to include cultural awareness standards and monitoring mechanisms in Service Level Agreements
    - ◊ to review and improve physical access and public information
    - ◊ to identify one change per service to develop culturally sensitive services
    - ◊ to encourage the development and use of research-based evidence to improve the health outcomes for BME patients
    - ◊ to acknowledge, encourage and support good practice and celebrate individual/service achievements through an annual Trust award ceremony
    - ◊ to encourage partnership arrangements with statutory organisations and voluntary/community groups
    - ◊ to plan for the growth of GRIP's face-to-face language interpreting and advocacy services to 40,000 contacts a year
    - ◊ to develop methods for disseminating information, advice and guidance to service managers about ways to improve access and corporate commitment to improving equality
    - ◊ to ensure that public meetings/user consultation do not clash with religious festivals
    - ◊ to share learning with PCGs and support them to begin work on cultural competence in general practice.

6.9.9 **Riverside Community Health Care** has a Valuing Diversity Strategy which is intended to help it develop services which are open, equally accessible and culturally competent to all sections of the community. The Strategy is the result of widespread consultation in 1999 with Trust staff, local PCGs and health authorities, local CHCs and community groups.

The Strategy is divided into a number of sections:

- strategic - to develop a local framework to address inequalities in health care and employment practices which includes mechanisms for monitoring changes in local practices. This will involve developing:
    - ◊ local services which examine various ways to assess health needs, reduce health inequalities, listen to users and public views and work in partnership with local organisations to improve local health and health services; ensures that health services make the best use of quantitative and qualitative information to target local patterns of illness/conditions; pulls together existing structures and resources to support and monitor the priorities identified
    - ◊ a local workforce which is drawn from all sections of the community and is knowledgeable about the needs of the diverse population it serves, and capable of responding appropriately to ensure that the local population get the best possible health promotion, treatment and care
    - ◊ a local culture where all staff whatever their background feel valued and receive equal treatment, and all service users and their families feel valued and receive services appropriate to their needs
- structures
    - ◊ an Equal Opportunities Committee working with local PCGs to develop local strategies to address inequalities in service and employment planning practices and to mobilise and involve local people in service planning
    - ◊ a Race Equality Action Group to contribute towards the raising of staff awareness and development of policies and procedures to underpin the Trust's commitment to equality and diversity
    - ◊ Information and Planning Group to ensure that the Trust is making the best use of quantitative and qualitative information on how local patterns of illness and service use differ according to ethnicity. This process will inform local health priorities and future Health Improvement Programmes
- addressing inequalities in local health care - coronary heart disease, diabetes and cancer have been prioritised for local health care and research indicates that BME communities are more adversely affected by these conditions. Other issues include improving the access to sexual health services for BME communities by providing advocates, female practitioners and staff training in anti-discriminatory service provision and service for people with haemoglobinopathies.
- priorities for local action
    1. involvement of local people and service users, including those from the BME communities in service planning
    2. a co-ordinated approach to promoting the health and well-being of recent refugees
    3. a co-ordinated and comprehensive language and interpretation service
    4. health promotion partnerships
    5. improved quality, coverage and analysis of ethnic monitoring data

6. training for managers on diversity awareness and for front-line staff on cross cultural communication
7. tackling racial harassment
8. implementing the Disability Discrimination Act 1995
9. ensuring that local staff profile as far as possible reflects their communities.

6.10 The Local Authorities and FUD

6.10.1 Two local authorities - the City of Westminster and the Royal Borough of Kensington and Chelsea - are covered by the Health Authority.

6.10.2 As originally conceived, the FUD Strategy was a strategy for the Health Authority focusing on health issues. The two boroughs participate in the Facing Up to Difference Strategy Group.

6.10.3 Since then, the partnership agenda has moved on significantly. For example, the Disability Discrimination Act 1995, the Race Relations (Amendment) Act 2000, the Best Value regime, the development of Local Strategic Partnerships and local authority scrutiny and overview of the health economy, the setting up of two borough-based primary care trusts.

6.10.4 These policy and organisational changes will result in more in-depth partnership work with many stakeholders, including the health sector. The requirements of the Race Relations (Amendment) Act 2000 will mean that the two local authorities will focus more strongly on equality issues in future, including health equality issues.

6.10.5 The BME communities experience a number of inequalities compared to the general population. These changes have the potential to lead to the greater involvement of the BME communities with the local statutory sector and to strengthen their voice with all service commissioners and providers.

7 CONCLUSIONS

7.1 The Scope of the Evaluation

7.1.1 This evaluation is primarily an impact assessment of the FUD Strategy:

- has the Strategy provided leadership for equalities work in the health sector and encouraged commitment to and accountability for equalities work?
- to what extent has the Strategy helped the Health Authority, PCGs and Trusts to work towards reducing unacceptable variations in health status and in the experience of using health services where such variations are attributable wholly or partly to ethnicity and/or cultural differences?
- how can the Strategy be taken forward given the policy and organisational changes subsequent to its formulation?

7.2 Leadership, Ownership and Accountability

7.2.1 The Strategy was originally designed to be a set of principles with a clear and cohesive action plan for the Health Authority. Its intent was to provide a wide framework for equalities work, not a detailed workplan, to guide processes, not to prescribe outcomes. It served to operate in the background, focusing attention on equalities and guiding action to achieve it, with the ultimate aim that equalities work should be part of ordinary, mainstream health planning and provision, a 'blue cheese' approach.

7.2.2 The Health Authority's Facing Up to Difference Strategy has had an impact on the work of the Health Authority, the PCGs and the Trusts to address health inequalities caused by ethnicity.

7.2.3 Through the FUD Strategy Group, leadership for equalities work was provided to the Health Authority, PCGs and Trusts. That the Health Authority Chief Executive chaired the Group was a significant factor in this achievement.

7.2.4 The Strategy, through the Steering Group, has encouraged the PCGs and Trusts to give organisational ownership and to develop their own local equalities policies and action plans. The Steering Group has also provided a forum for accountability for health equalities work in the two boroughs.

7.2.5 The flexibility of the Strategy has also allowed issues and organisational structures which were not present when it was formulated in 1998, e.g. workforce diversity,

regeneration schemes and the development of PCGs, to be taken account of and incorporated.

7.2.6 The setting up of the BME Health Forum in February 2001 has provided a formal mechanism to consult and involve the BME communities in the planning and delivery of health services. It will continue in existence after the Health Authority ceases to exist in April 2002, covering both boroughs and hosted by Westminster PCT, with funding agreed until December 2003.

7.2.7 In summation, the Strategy has served to put into place an equalities framework for health commissioning and provision in Kensington and Chelsea, and Westminster.

7.3 FUD Commissioning Principles

7.3.1 The Strategy formulated five additional principles specific to the commissioning of services for an ethnically diverse population:

- information on BME communities
- health needs of BME communities
- access to services
- appropriate services
- recognising variations in BME communities.

Information on BME communities

7.3.2 One of FUD's objectives was to improve the data on the minority communities in the Health Authority's area and this led to the setting up of the Social Mapping Project. This very ambitious project has not achieved its aims and an internal evaluation has recommended that the Project, in its current form, is not continued.

7.3.3 As a result, there is no central information resource on the BME communities which can provide the detailed information originally envisaged. To be able to use data meaningfully, it is necessary to be able to compare patient data to the population as a whole.

7.3.4 There are differences in professional opinion about the need for and feasibility of such a database project. If this objective is to be further pursued, there is a need for the organisations involved to agree an effective methodology to improve data collection, aggregation and utilisation. Increasingly, information on service users will be available.

Health needs of BME communities

7.3.5 Given the absence of data from the Social Mapping Project, the Health Authority Public Health Intelligence and Evaluation Unit has used a variety of other data sources to provide information on BME communities.

7.3.6 The NHS London Regional Office has set an 80% target for ethnic coding by 2002. Currently, the Trusts achieve variable levels of ethnic coding. If they achieve the Health Authority's 80% target for ethnic coding, this will provide significant data on BME service users, particularly if the new PCTs are able to achieve similar levels.

7.3.7 The development of the BME Health Forum in February 2001 has been a key means by which the Health Authority has improved its understanding of the needs of its BME communities. The Forum, through its task groups, has conducted a range of qualitative research into the health needs of BME communities based on extensive community consultation. Much of the work of the Forum has sprung from the consultation that led to its formation. In the future, it would be reasonable to expect that the work of the Forum is increasingly based either on known need or is a gap analysis exercise, which can then lead to an ordered choice of priorities and action thereon.

Access to services

7.3.8 The Health Authority has provided or commissioned a range of services to tackle obstacles to access caused by language or culture, and to increase awareness by health staff of the problems BME communities can face in accessing health services.

7.3.9 These have included the work of the Health Authority's Community Health Development Teams, funding the PCGs through Local Development Schemes to improve access primary care, and the commissioning for specific services for identified vulnerable groups such as refugees and asylum seekers, e.g. Refugee Support Service.

7.3.10 The Health Authority and all the Trusts provide a range of training for staff on equalities and cultural sensitivity. The impact of this training should be evaluated.

7.3.11 Through the establishment of the BME Health Forum, the Health Authority has developed links and long-term working relationships with representatives of the BME communities. Both the PCGs have User Involvement Groups by which residents, including those from the BME communities, can be consulted and involved.

7.3.12 The Health Authority has also funded health advocacy training schemes so that people, including BME service users, can be supported when they need health care.

7.3.13 Many of these services meet the needs of some of the most vulnerable members of the BME communities: refugees and asylum seekers. There is still a need to look at

the experience of the settled communities. Research evidence still clearly shows that they continue to face barriers to accessing services.

Appropriate services

7.3.14 Through the Facing Up to Difference Strategy Group, chaired by the Health Authority's Chief Executive, Trusts have been encouraged to develop their own equalities strategy. All now have one in place. The Group has also been the means by which the appropriateness of care delivery has been monitored.

7.3.15 The Health Authority has provided or funded a number of services to GPs to help vulnerable groups access primary care.

7.3.16 All the Trusts and PCGs provide a range of training to staff in how to provide an accessible and appropriate service to minority communities.

7.3.17 The effect of these initiatives should be evaluated in order to find out whether they have led to more appropriate services for the BME communities.

Recognising variations in BME communities

7.3.18 The BME Health Forum has been the formal channel for the Health Authority and Trust to make contacts with the BME communities and for those communities to develop working relationships with health commissioners and providers.

Local initiatives based on FUD criteria

7.3.19 The Health Authority has provided or funded a wide range of services for the BME communities within the framework set by the FUD criteria. In addition, the Health Authority has provided a Voluntary Sector Small Grants Fund of £200,000 in 2001-02.

7.4 Conclusions on the Impact of FUD

7.4.1 FUD has made a difference. It is clear that the Strategy has provided leadership for equalities work in the health sector. The Strategy has also encouraged commitment to and accountability for equalities work in KCW's area from the health sector.

7.4.2 The Strategy has provided the Health Authority, PCGs and Trusts with a flexible framework for their work in reducing the health inequalities experienced by the BME communities. This in turn, has led to a range of initiatives and services to improve access to health services and the experience of health services for KCW's BME communities.

7.4.3 Overall, in the next phase of work, there needs to be more explicit links from national research on need, to the identification of particular local needs, to prioritising action, to implementing action and evaluating it. This should involve:

- an agreed equalities framework for the PCTs and Trusts in the two boroughs
- continuing co-operation and co-ordination between these bodies and other key local stakeholders
- an increasingly rigorous approach to the setting of performance indicators and monitoring of every aspect of the Strategy.

7.5 Issues for the Future

7.5.1 Since the development of FUD, there have been significant developments in health structures and policies, for example:

- NHS Plan
- National Service Frameworks
- Patient Advocacy and Liaison Service and Patient Forums
- Race Relations (Amendment) Act 2000
- Local Strategic Partnerships
- local authority scrutiny of health services
- workforce issues - fair access to recruitment, training and promotion.

7.5.2 These new policies and structures now need to be taken into account and integrated into a health equalities strategy for the two boroughs.

7.5.3 However:

- the next 18 months will be a time of great organisational change, with competing agendas and much effort spent on transitional issues - what priority will be given to equalities work?
- who will be the new 'champions' for equalities work and will they have access to senior levels?
- what funding will be available?
- how will the formation of two separate PCTs for Kensington and Chelsea, and Westminster impact on equalities work?
- how will the relationship between the PCTs and the acute Trusts impact on equalities work?
- what will be the role of the Strategic Health Authority in equalities?
- how will the existing means for consulting and involving the BME communities relate to the new range of bodies for patient and public involvement?
- what will be the impact of the Race Relations (Amendment) Act 2000 on equalities work in the health sector?

7.5.4 The scope of this evaluation was to review the impact of FUD over the last three years. However, it was very apparent during the evaluation, that health equalities work is about enter a new policy and organisational context. In this section, we outline some of the issues which will arise as a result.

Agree a framework for diversity and equalities work taking account of the statutory duties imposed by the Race Relations (Amendment) Act 2000

- ensure that there is a proper handover of equalities policies, practice and systems from the organisations which will cease to exist in April 2002
- bring FUD up to date by taking account of the changes in policy and organisational structure since 1998
- to provide for accountability, identify a replacement for the FUD Strategy Group and ensure that it has the commitment and participation of senior staff
- decide whether (and what) performance indicators for equalities work should be introduced
- ensure that the successor organisations have a mechanism to speedily resolve what equality approaches and services they wish to maintain and continue
- identify areas of cross-borough equalities work

Information and needs assessment

- identify the need for data on BME communities and the use to which it will be put, review the availability of such information and agree minimum standards for data collection, taking into account the experiences of the Social Mapping Project
- achieve a high level of accurate ethnic coding in primary care and in-patient care
- further develop equalities performance indicators so that commissioning expectations are clear and achievement can be assessed
- ensure that the health needs of new or hidden communities can be ascertained

Access, appropriateness, user and community involvement

- review the current mechanisms for formal and informal patient and community involvement, particularly in the light of the forthcoming introduction of PALS and Patient Forums

Working in partnership

- given the forthcoming organisational separation of health commissioning for the two boroughs, review the mechanisms and future areas of joint working between the two PCTs, the two local authorities and service users and community groups in Kensington and Chelsea, and Westminster
- review the involvement of the health sector in Local Strategic Partnerships and other borough based initiatives
- take account of the new role for local authorities to scrutinise local health services
- clarify the role of the Strategic Health Authority in health equalities.

7.6 Taking FUD Forward

7.6.1 There will be a continuing need for an equalities strategy to engage both commissioners and providers because:

- there is substantial evidence to show that BME communities generally suffer poorer health and have less access to health services than the majority population
- there are morbidity and mortality profiles which specifically affect ethnic minorities
- there are increasing expectations from the minority (and majority) communities for the NHS to be more responsive to the health and health care needs of specific groups in the population
- the effective and equitable delivery of health services to the BME communities is an important Government priority.

7.6.2 The Government is encouraging health agencies to look to Local Strategic Partnerships to address health inequality issues. There must be a strong assumption that, from April 2002, most health and care issues will be considered on a borough wide basis. However, the Trusts will continue to draw their patients from a wider geographical area; GP practices may also draw patients from communities which cross borough boundaries.

7.6.3 In order to ensure that BME residents living in the two boroughs are served by health agencies with effective equalities practice, it will be important that:

- the two PCTs introduce equalities strategies
- there is a forum for the two PCTs and Trusts to develop and implement a equalities strategy collaboratively
- the Local Strategic Partnerships are influenced to give priority to health inequality issues.

7.6.4 It will be important to provide the public with a clear route through which they can be consulted and involved in the health sector, particularly given the imminent arrival of new consultation fora. This will involve clarifying the role and expectation of the BME Health Forum in the new organisational and policy context.

7.6.5 The membership of the current Facing Up to Difference Strategy Group may need to be reconsidered as the two boroughs and the Local Strategic Partnerships play a greater role. Many health services have a social care dimension. Given the legislative requirements for local authorities and health organisations to increasingly work together in partnership, there will be an increasing number of collaborative ventures. It may be that a wider group, based on the PCTs in the North West London Strategic Health Authority would be useful and able to feed in directly to the Strategic Health Authority.

7.6.6 The Race Relations (Amendment) Act 2000 will have a significant impact on equalities work generally. The FUD Strategy goes a long way to fulfilling the first part of the Race Equality Scheme in identifying which functions and policies are relevant to the duty. It also recognises the importance of assessing and consulting on the likely impact of these functions. In addition to the general duty to promote racial

equality, the expected specific duties, such as monitoring staff by ethnicity, a duty to assess the impact on racial equality of proposed policies and to consult on them and a duty to monitor the impact on racial equality of existing policies and practice, will act as a spur for setting and monitoring equality performance indicators.

7.6.7 The Act aims to make the promotion of race equality central to the way public authorities work. The continued implementation and development of Kensington & Chelsea and Westminster Health Authority's Facing Up to Difference Strategy by the two new PCTs and the Trusts will be a key way to meet this duty.

APPENDICES

A1 List of Organisations Consulted

Kensington & Chelsea and Westminster Health Authority

John H James, Chief Executive

Sally Hargreaves, Director of Partnership and Performance

Yohannes Fassil, Head of Diversity and Community Development

John Hamm, Head, Public Health Intelligence and Evaluation Unit

Kensington and Chelsea Primary Care Group

Terry Bamford, Chair designate

Simon Kenton, Service Development Manager

Westminster Primary Care Group

Anna Barnes, Primary Care Development Manager

Kensington & Chelsea and Westminster Community Health Council

Judith Blakeman, Chair

Chelsea & Westminster Healthcare NHS Trust

Therese Davies, Director of Nursing and Patient Services

St Mary's Hospital NHS Trust

Julian Nettel, Chief Executive

Susan Osborne, Director of Nursing

Esther Moloney, Patient and GP Bureau Manager

Brent, Kensington & Chelsea and Westminster Mental Health Trust

Gareth Jones, Equalities Facilitator

Parkside Healthcare NHS Trust

Jinty Wilson, Development Manager

Chris Bevan-Davies, Quality, Complaints and Legal Co-ordinator

Riverside Community Health Care NHS Trust

Adrian Mayers, Service Improvement Manager

Royal Borough of Kensington and Chelsea

Bob Page, Head of Performance, Social Services Department

City of Westminster

Sabeeha Mannan, Policy Manager, Race Equality, Policy and Communications Directorate

Colleen Williams, Policy Manager, Health, Policy and Communications Directorate

BME Health Forum

Aisling Byrne, Manager

Samira Ben Omar, Manager

Voluntary Organisations

Penny Marshall, Health and Social Care Project Worker, Voluntary Action Westminster

Sue Newton, Health and Social Care Officer, Chelsea and Notting Hill Social Councils

Zrinka Bralo, Director, Migrant and Refugee Communities Forum

Mohamed Farah, Somali Health Advocacy Worker, Somali Welfare Association