Kensington, Chelsea & Westminster BME HEALTH FORUM:

# INVOLVING BME COMMUNITIES IN NHS TRUSTS' DIVERSITY AND EQUALITY POLICIES AND PRACTICES

March – December 2002

This was a 9-month strategic policy initiative aimed at highlighting good practice, developing innovative ideas and working to develop a set of minimum standards for good practice on community involvement in NHS Trusts' Diversity and Equality policies, practices and initiatives, including their Race Equality Schemes.

The *BME Health Forum* set up a multi-agency steering group, with representatives from NHS Trusts, local authorities and community/voluntary sector groups for the project to steer the work of the Task Group. This is the final project report – bring together the recommendations and action points from the events organised as part of this Task Group:

- Consultation Meeting on NHS Trusts Race Equality Schemes (June 2002)
- Workshop: Employment, Recruitment and training initiatives for local people in the NHS (Oct 2002)
- Workshop: Performance Management, Accountability and Ethnic Monitoring (Nov 2002)
- Workshop: partnership Working (December 2002)

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## MEMBERS OF PROJECT STEERING GROUP

| | |
|---|---|
| Mark Beauchamp | RBK&C |
| Judith Blakeman | KCW CHC |
| Zrinka Bralo | MRCF |
| Aisling Byrne | BME Health Forum |
| Fidelma Carter | Westminster PCT |
| Bridget Davies | Minutes |
| Yohannes Fassil | Westminster PCT |
| Katija Hiujbers | MRCF |
| Gareth Jones | CNWL MHT |
| Oliver Morgan | K&C PCT |
| Colleen Williams | Westminster City Council |
| Christine Wingfield | RBK&C |
| Samira Ben Omar | BME Health Forum |
| Renee de la Haye | K&C PCT |
| Joe Hegarty | Westminster PCT |
| Bob Page | RBK&C |
| Nick Tittle | Community Safety Team |
| Kate French | Facilitator |
| Mary Mesmain | Chelsea & Westminster Hospital |

## A Consultation Meeting on NHS Trusts Race Equality Schemes (June 2002)

### SUMMARY & RECOMMENDATIONS

The objective of this workshop was to facilitate a co-ordinated approach for NHS Trusts and local authorities in Kensington & Chelsea and Westminster to consult voluntary and community groups on their recently-published *Race Equality Schemes*.

By bringing together representatives from community & voluntary groups, with service-providers, commissioners and managers from statutory bodies, the aim was to focus the consultation and feedback discussion on key aspects of the requirements of the Race Relations Amendment Act.

Presenting the Strategic Policy Framework, Sarah Corlett from the Department of Health/Commission for Racial Equality, highlighted that production and publication of *Race Equality Schemes* is the means to reviewing policies, procedures and engaging local communities, and not an end in itself. The 31 May deadline to publish Race Equality Schemes was the beginning of a process to improve delivery and equality in public services, and to involve local communities in this process, and that the challenge now is to mainstream this process to ensure that race equality is a central part of main-streamed service provision, commissioning and management.

Following presentations on Race Equality Schemes by 5 NHS Trusts and 2 Local Authorities, workshops on four key topics were held:

- Performance Management & Accountability
- Ethnic Monitoring
- Employment, Recruitment & Training
- Partnerships & Co-ordination

Each workshop came up with a series of recommendations, including examples of good practice that are already happening in the local area. These recommendations are listed below.

The following people made presentations on the Race Equality Scheme of their organisation:

Yohannes Fassil, Head of Diversity, Westminster PCT
Paul Haigh, Chief Executive, K&C PCT
Jonathan Sampson, St Mary's Hospital
Amanda Harrington, Chelsea & Westminster Hospital
Gareth Jones, Central NW London Mental Health Trust
George Bishop, Royal Borough of Kensington & Chelsea
Daren Townsend, Policy Department, Westminster City Council

### FEEDBACK & RECOMMENDATIONS FROM WORKSHOPS:

The following are the findings and recommendations form the Workshops:

#### A Performance Management and Accountability:

- Routine collection of information was not in GPs contracts, but could be introduced beneficially. It will need to be made clear how this will benefit service provision.
- A set of standards and guidelines is needed for quality assurance in performance-management and accountability, e.g. PQASSO. These standards will need to include

monitoring the implications on race equality of mainstream policies, services and initiatives of statutory bodies
- Need for co-ordination and sharing of best practice to ensure consistency across all practices.
- The role of PCTs as commissioners: making sure systems are in place and that race equality issues and obligations are included in service level agreements with other service- providers – including voluntary / community sector groups. [The Association of London Government and London Voluntary Service Council have produced a Tool Kit for Voluntary Sector groups: see http://www.rota.org.uk/attachments/toolkit.pdf]
- Voluntary and community groups – particularly umbrella forums and networks – need to be involved in strategic policy networks related to performance management and accountability. They will need to be adequately funded and resourced for this.
- Develop the capacity for Patients' Forums as mystery shoppers – this will require funding. Linked to this, performance- management and accountability issues related to race equality obligations for public bodies need to be included in the agenda in terms of current developments related to PALS, Patient Forums, and other user / public involvement bodies.
- The need to think about accountability, and the need to develop clear standards and genuine partnership.
- Gaps in services and unmet needs - how to get them commissioned. Could the Local Strategic Partnership be a vehicle for this? Need for PCTs to clarify how they, as leads on health on the LSP, will consult with, and involve stakeholders working on health issues.
- It was felt that there must be co-ordination amongst all public bodies in each borough (K&C and Westminster) in their on-going consultations for their race equality schemes; and common standards for this should be developed.

## RECOMMENDATIONS ON PERFORMANCE MANAGEMENT & ACCOUNTABILITY

(i) Develop the capacity for Patients' Forums as mystery shoppers – this will require funding. Linked to this, performance management and accountability issues related to race equality obligations for public bodies need to be included in the agenda in terms of current developments related to PALS, Patient Forums, and other user / public involvement bodies.

(ii) In their roles as the lead agencies for health on LSPs, the PCTs need to develop – with relevant partners – procedures and processes to ensure accountability and involvement of the various stakeholders.

(iii) It was strongly recommended that statutory bodies – at least in each borough – should co-ordinate in their annual consultations on race equality schemes – using community forums and networks (see below – under Partnerships).

(iv) Any standards and guidelines which are developed will need to include details on how implications on race equality of service provision, policies or initiative will be measured.

## B Ethnic Monitoring:

1. Collection of data is only one part of the process: those who collect must be well trained in coding and recording, and in understanding why data is being collected. Training should be provided and open to community and voluntary groups.
2. Individuals, especially refugees and asylum-seekers, can be sensitive about some of the questions asked – hence need to clarify and explain why data is collected and how it will help improve service -delivery.

3. Linked to this is the need to raise awareness amongst health service providers at the front line (e.g. receptionists, health visitors, etc.) on the entitlements of refugees & asylum -seekers to health care.
4. Given the difficulties in social mapping and developing an up-to-date database of local communities, it was recommended that an accessible mapping exercise be developed containing all local data – including, for example, needs assessments for Regeneration bids, evaluations from SRB projects, etc.
5. There are primary and secondary degrees of ethnic monitoring, used for different purposes.
6. The better the explanations when collecting information, the better will be the answers given.
7. Co-ordination amongst statutory bodies in same geographical areas is advised to ensure the same categories and local specifics of any data collection. IT co-ordinators and users should be brought together, with a shared coding system amongst NHS Trusts providing services in each borough. An example of a locally-adapted set of ethnic coding categories is included in Westminster PCT's RES – see Appendix 3.
8. Co-ordinating and collecting information and making it relevant is a hard task for small organisations, especially given their capacity and resource limitations.

RECOMMENDATIONS ON ETHNIC MONITORING

(v) To circulate the adapted ethnic coding categories presented by Westminster PCT – as part of their RES - to local NHS Trusts and Local Authorities to work towards collection of similar locally-specific data – including the possibility of covering the Strategic Health Authority area (see Appendix 3). See example from Guy's and St Thomas' Hospital patient diversity categories – Appendix 3.

(vi) It was recommended that a mapping exercise be undertaken containing all local data on BME communities – including needs assessments for Regeneration bids, evaluations from SRB projects, academic studies, etc. Westminster City Council, for example, have recently commissioned Imperial College to undertake a Ethnic Minority Needs Audit. All these sources of data should be available and accessible – i.e. in the Resource Centre.

(vii) Any training or awareness-raising initiatives on ethnic monitoring should include information on the entitlements of refugees & asylum seekers to health care.

C Employment, Recruitment and Training:

- Need to produce information on the range of qualifications required for working in the health sector, and how to access courses and employment for this.
- Trusts should be encouraged to develop opportunities for volunteering, or in placements – possibly in partnership with voluntary/community groups running courses on pathways into employment and health advocacy.
- Need to undertake joint work and develop links with the Employment Service, and to highlight the problem of benefits being affected – the '*benefit trap*'.
- Interpreting courses often lead to sessional work and are not sustainable – i.e. it is not worth it for people to come off benefits if they only get occasional sessional work.
- Language barriers, and sometimes lack of crèche facilities, mean that some courses and volunteer opportunities are not accessible.
- Many people have qualifications from other countries: need to circulate information on how to adapt these for employment in Britain.

- Information should be circulated on ESOL courses that are profession-specific and related to the requirements of particular professions / jobs – i.e. requirements for any exams, terminology related to specific professions, etc.
- Need to raise the profile of health advocacy as a career in local communities, amongst interpreters, as well as amongst service- providers and managers. The King's Fund, for example, have a major investment project on developing health advocacy within BME communities in London; see http://194.66.253.160/eGrants/html/health_advocacy.html.
- Provision of a guaranteed interview at the end of a course would be an encouragement to students, especially with local health service providers, i.e. GRIP, hospitals recruiting health care assistants, etc.
- How can people go from one level of education to another – the need to provide information and contacts of support groups that assist with this.

RECOMMENDATIONS ON EMPLOYMENT, RECRUITMENT & TRAINING

(viii) NHS Workforce Confederation or other co-ordinating body on employment should produce information on the range of qualifications required for working in the NHS, and how to access courses and employment to this end.

(ix) NHS Trusts should be encouraged to develop opportunities for volunteering or in placements – possibly in partnership with voluntary/community groups running courses on pathways into employment and health advocacy.

(x) Related to this, provision of a guaranteed interview at the end of a course would be an encouragement to students – especially with local health service providers – i.e. GRIP, hospitals recruiting health care assistants, etc.

(xi) All employment initiatives need to take into account the problem of the 'benefit trap' – i.e. in relation to volunteering, sessional work, etc.

(xii) Employment projects need to take into account language barriers and lack of crèche facilities, which mean that some courses and volunteer opportunities are not accessible.

(xiii) Information should be circulated on ESOL courses that are profession-specific and related to the requirements of particular professions / jobs – i.e. requirements for any exams, terminology related to specific professions, etc.

(xiv) Employment projects should consider raising the profile of health advocacy as a career in local communities, amongst interpreters, as well as amongst service providers and managers. There are additional resources being focused on the area of health advocacy with a view to improving advocacy provision – particularly for BME communities – for example, by the King's Fund.

D Partnership and Co-ordination:

- Consultation on Race Equality schemes needs to be co-ordinated within, as well as between, the different hospital trusts, PCTs and Local Authorities. This raises concerns around how the whole consultation process will be managed and co-ordinated so that community organisations, already under-resourced, are engaged in a meaningful way, rather than each trust and local authority undertaking their own consultation exercise.
- Need to develop a common consultation framework that all partners – PCTs, Hospital Trusts, CNWL Mental Health Trust, both Local Authorities and voluntary and community organisations – sign up to. It was suggested that the framework needs to take into account and adopt current examples of good practice, including the methodology approach developed by the BME Health Forum in engaging BME communities through the different Task Groups; and the process undertaken in

establishing the needs of the different communities, as well as the current gaps in service-provision.
- Currently, the issue of partnership is forced on geographical boundaries – particularly in relation to the PCTs and the Local Authorities - rather than based on the needs of the community, which places strong emphasis on cross-borough working. This is not only true of the community, but also in relation to Hospital and Mental Health Trusts.
- Need to look at existing models of good practice at a strategic level, on ensuring that the impact of local policies and service- provision as well as local initiatives such as Sure Start, SRB, Connexions, LSPs, on BME communities is monitored on an on-going basis. One example that was highlighted was to look at developing a very similar structure to – or reviving - the *Facing Up to Difference Strategy Group* which cut across all the different Trusts, both Local Authorities, umbrella and well established grassroots community organisations as well as SRB and other similar programmes, with the aim of addressing BME issues in a strategic and co-ordinated manner and with ownership from chief executive level within the respective organisations.
- Issue of geographic / locality funding v cross- borough / area nature of communities. Thus, there is a need to look at current funding programmes and see how they can be best co-ordinated to benefit the community as a whole as many BME communities and community organisations currently fall through the net either through lack of awareness of these programmes or because they fall outside a programme's catchment area.
- Genuine partnership means developing the capacity support for community organisations- including providing core funding. In order for grassroots and umbrella community organisations to engage effectively in local policy developments related to health and social care issues, they need to be well resourced so that they are able to participate on an equal level with statutory agencies and other more established voluntary and community sector organisations.
- In order to have an effective and working partnership, the issue of power relationships between the community and statutory sectors needs to be explored, as well as the issue of who decides which community to consult and /or fund, and why? How are consultation time scales determined and how are community organisations involved, if at all, in determining these time scales?

RECOMMENDATIONS ON PARTNERSHIP & CO-ORDINATION

(xv) It was felt that consultation on Race Equality Schemes needs to be co-ordinated within, as well as between, the different hospital trusts, PCTs and Local Authorities. This could be done on an annual basis, at least within each borough boundary.

(xvi) There is a need for PCTs to clarify how they, as leads on health on the Local Strategic Partnership (LSP), will consult with and involve stakeholders working on health issues – including community groups.

(xvii) There is a need to look at existing models of good practice at a strategic level to ensure that the impact of local policies and service provision as well as other local initiatives (LSPs, etc.) on BME communities is monitored on an on-going basis. It was felt that there needs to be a strategic policy group to oversee this – and one that should include representation from the community and voluntary sector.

One example that was highlighted was to look at developing a similar structure to the *Facing Up to Difference Strategy Group* which involved all local NHS Trusts, both Local Authorities, Umbrella and well established grassroots Community organisations as well as SRB and other similar programmes, with the aim of addressing BME issues in a strategic and co-ordinated manner and with ownership from chief executive level within the respective organisations.

(xviii) There is a need to look at current funding programmes and see how they can be best co-ordinated to benefit the community as a whole, as many BME communities and

community organisations currently fall through the net either through lack of awareness of these programmes, or because they fall outside a programme's catchment area.

(xix) The issue of on-going funding for community groups' capacity development was raised, as without the capacity and resources for involvement, community groups and the communities they work with will not be able to be engaged in a meaningful manner. Related to funding, it was felt that co-ordination on strategic policy issues and area-based funding initiatives would facilitate a more partnership approach to funding.

## 2. STRATEGIC POLICY FRAMEWORK

Sarah Corlett, Dept of Health / CRE introduced the Strategic Policy Framework for Community Involvement in Race Equality Schemes, prepared by the CRE. With her colleague, she is seconded to the CRE to help develop its approach to working with health and social care organisations, and to see how to influence the NHS from a strategic perspective on race equality issues at local and national levels.

- The Context – Stephen Lawrence Inquiry Report; Government Response; Race Relations Amendment Act – specific and general duties
- Partnership, Consultation and User Participation
- Community Involvement in Race Equality Schemes – production of Race Equality schemes is the means, not the end. 31 May was the beginning of a process of consultation, monitoring, review and revision, to improve delivery and equality in public services.
- Performance- management of race equality
- What is the role of the CRE?
- Enforcement & monitoring

For full details on Sarah Corlett's presentation, see Appendix 2.

## 3. PARTNERSHIP WORKING – by Kate French

**MERGER … PARTNERSHIPS … COLLABORATION … NETWORKS**

**Our thinking about organisations – partnerships – how to change things – is being challenged via many disciplines**

- How we think about partnerships depends partly on how we think about organisations: the 'machine' linear viewpoint or the 'complexity' non linear perspective – the difference between throwing a rock and throwing a bird [Richard Dawkins's analogy]
- The linear, cause and effect type of thinking, 'one right way' approach is being questioned by economists, natural scientists, organisational theorists and others – complex adaptive systems thinking is challenging notions of control, change, progress, predictability and static order

**Complex systems – some characteristics**

- Thrive in tension and paradox – on the edge of chaos, where innovation and creativity will occur
- Systems are embedded in other larger complex systems – leaders can't take up a position outside of the system and 'shout directions'

- Change is non linear – small changes can have big effects, and big changes no effect at all
- Very complex outcomes can emerge from a few simple rules [principles for action] – lots of complex targets can stifle adaptive ability and creativity
- The elements of the system can change themselves – imposed change can lead to unhappy and unintended consequences – the lesson is not to make the bird become more rock -like – bird behaviour, seemingly complex, revolves around a few simple rules – so change is successful where a natural pattern and advocated change are linked [the desire to be in a birdbath].

Complex systems thinking does not address the notion of power and power differences between key players. In partnership development, some agreement of what power is and how it is shared is necessary to achieve a more level playing field.

**Generative relationships in partnerships**

'When individuals with different experiences come together to act for some common purpose, they form a generative relationship that leads to creative ideas that leads to creative ideas that neither party could have dreamed up alone'. Brenda Zimmerman of McGill University presents 4 aspects of this relationship:

- **S**eparateness: differences in background, skills, diversity and active respect for difference – generating a fuller picture, seeing things from various perspectives
- **T**alking and listening: real opportunities to talk and listen; permission to challenge the status quo; or implicit assumptions [see also Senge's notion of dialogue]
- **A**ction opportunities: acting together to co-create something new – this implies shared access to resources. It may involve lateral thinking, what other parts of the wider system can do to bring about change
- **R**easons to work together: there has to be some mutual benefit derived from the project

Rules, plans and structures are necessary to do things. It is suggested by those working with a complex adaptive systems framework that a few simple rules or minimum specifications are necessary. These specifications should

- Point the direction of change [ e.g. an action has to be taken/in place within certain time frame]
- Set absolute boundaries [e.g. can't go over budget limit]
- Provide resources for generative relationships
- Give permissions for trials or innovative approaches

**INTER-ORGANISATIONAL NETWORKS**

There has been considerable research in the development of inter-organisational networks across private and public sector organisations, and the findings of the research have relevance to more formal and informal types of partnership.

WHAT ASSISTS COLLABORATION?

- Valid rationale
- Choice based on likelihood of trustworthiness, shared strategy and understanding roles and cultures
- Flexible process that can take on changes in design
- Valid leadership and governance mechanisms – how to make decisions, lead organisation, information needs of all, rules of conduct and protocols

MOTIVES FOR COLLABORATION

- To increase resources, reputation, skills and enhance own organisation's legitimacy and validity
- Better output and outcomes
- Fast learning

- Reduce risk and improve stability where taking lead in innovation in uncertain climate
- To pursue common or mutually beneficial goals

TYPES OF CONNECTION REQUIRED IN COLLABORATIVE RELATIONSHIPS

- Flows of resources and activity links that lead to interdependence
- Flows of information to influence people's knowledge and perceptions and guide their decisions and actions
- Flows of mutual expectation that influence people's perception of risk and opportunity, fairness and trust

POTENTIAL BENEFITS

- Enhanced learning and innovation
- More rapid and effective decision making
- Improved responsiveness and flexibility

**THE THREE PHASES OF PARTNERSHIP DEVELOPMENT**

1. PRE -NETWORKING

- Areas of interest of each agency
- Scrutinising joint interests and concerns
- Does each agency see the other as having status and legitimacy in the field?
- What are the perceptions of the relative power of each partner and how a partnership will affect the power base of each agency?

2. DIRECTION -SETTING

- What are the values of each partner, and are there common values?
- What would be the common purpose of collaboration and what are our objectives?

3. STRUCTURING

- What structure do we want to take our work forward – types and frequency of meeting, membership, leadership
- What systems do we need to put in place to take decisions, share information, learn about each other's strengths, ideas and to agree areas of action?

**References:**

1. NHS Confederation leading edge briefing paper 'Why won't the NHS do as it is told – and what might we do about it?' Paul Plsek July 2001
2. Health Development Agency: Issues in Health Development Networked Organisations – an overview, Mike Pedler
3. The NHS Confederation Clinical Networks – a discussion paper 2001
4. South East Region NHS Managed Clinical Networks September 2000

FOR A FULL REPORT ON THIS EVENT, please see website:

http://www.kc-pct.nhs.uk/diversity/bmehealthforum.htm

http://www.westminster-pct.nhs.uk/diversity/bmehealthforum.htm

## B Workshop: Employment, Recruitment and training initiatives for local people in the NHS (Oct 2002)

**Held on Tuesday, 8TH October 2002 at MRCF**

**PEOPLE IN ATTENDANCE:**

| | |
|---|---|
| Carola Addington | K&C Social Council |
| Huda Al Amin | Mosaada Centre for Single Women |
| Salwa Al-Saeedi | W. London Health Professional |
| Magda Bartosch | Dalgarno SRB |
| Sandla Bhagi | Peabody Trust |
| Aisling Byrne | BME Health Forum |
| Fiona Collings | Brent PCT |
| Bridget Davies | Minutes |
| Renee de la Haye | K&C PCT CHOT |
| Aaron Eagle | Westminster PCT HR |
| Catherine Edwards | St. Mary's NHS Trust |
| Yohannes Fassil | K&C & Westminster PCTs |
| Gosaye Fida | Westminster PCT |
| Zufan Gebray | Student |
| Katija Huijbers | MRCF |
| Carol Hurd | City of Westminster College |
| Berivan Kittani | Interpreter/Health Activist |
| Verna Lyos | K&C College |
| Maisie McKenzie | K&C PCT |
| Noor Mohamed | |
| Dobrila Roganovic | RETAS/WUS |
| Jo Shim | W & K&C Community Health Council |
| Nanda Sirker | Golborne Sure Start |
| Cathy Taylor | Royal College of Nursing |
| Darryll Teal | NW Ken Sure Start |
| Kate Tomaselli | NW Ken Sure Start |
| Suzanne Worrica | Black Unity Forum |

**PRESENTATIONS.**

1. Sue Arnold, Assistant Director at the West London Workforce Confederation (Sue.Arnold@WMUH-TR.NTHAMES.NHS.UK)
2. Katija Huijbers, Co-ordinator of a Health Advocacy Course at the MRCF
3. (katja.huijbers@mrcf.org.uk ; tel 020 8964 4815
4. Verna Lyus spoke about the Employment and Training Project in North Kensington (v.lyus@kcc.ac.uk)
5. Fola Omotunde spoke about GRIP Interpreting Services' recruitment and training initiatives (Fola.Omotunde@westminster-pct.nhs.uk)
6. Catherine Edwards spoke about St. Mary's Hospital and gave an update on the services based in Paddington (Contact: Mary Collins, mary.collins@st_mary's.nhs.uk)
7. Dobrila Roganovic spoke of the work of RETAS (Refugee Education and Training Advisory Services) dobrila@wusuk.org.uk ; tel 020 7426 5840
8. Yohannes Fassil and Gosaye Fida spoke about the Refugee Doctors and Dentists Scheme in KCW. Contact: gosaye.fida@westminster-pct.nhs.uk ; tel 020 8451 8178

**DISCUSSION AND RECOMMENDATIONS**

- Specialised ESOL for health workers is needed – now offered by some colleges
- Geographical limits of most regeneration funding (Neighbourhood Renewal, SRBs, Sure Start) – this presents problems when putting together bids

- Placements, if in the statutory sector, can contradict the independent aspect of Health Advocacy
- Link up to independent Advocacy Service providers
- RETAS outreach sessions in community settings – contact RETAS for details
- Kensington & Chelsea College – more outreach work may be required
- Support from Sure Start staff – employment advisers more info. on outreach sessions
- Look at possibility of Sure Start providing grants for child care – individual grants, or cluster of people, eg. at St. Mary's – thought this would have to be done in a co-ordinated manner as not cost-effective for each individual Sure Start
- Some existing entitlements for child care, especially if studying – for access fund plus ESF course
- Child minder co-ordination in the Borough – people were not aware of this service
- Campden Charities – individual grants to Kensington residents
- Separate information session for migrant and refugee communities (BME HF plus MRCF, plus speakers). Jo Shim from the KCW CHC offered to co-ordinate this. **Contact** Jo Shim on 020 7706 7100.
- Finding the right child care can be difficult – hours available, etc.
- Work-based learning for adults, in job centers (district managers in Central and West London districts) – suggested co-ordinated task group to look at this
- Work placements are an important part of the courses – students could also have a choice!
- Work trial scheme suggested – to try a job for 2-3 weeks first
- Change in entitlements for asylum-seekers to work – until their status has been finalized – so may limit their ability to do placements
- Schemes need to include all kinds and levels of jobs. Will be included in PCT/K&CC scheme. To include Sure Start
- Publicise existing jobs in the NHS – recommend that HR departments make efforts to send their regular vacancy bulletins to local community groups
- Need to publicise how easy it is to find info, and how to access info.
- Changing mindset on opportunities
- Job centers coming into community groups to run sessions – Sure Start have 2 Outreach Workers
- Roadshows – K&C PCT plus K&C College, in spring, to tell people about jobs and courses – to include Sure Start and job center.
- Important to make commitment to students beyond courses – progression pathways
- CHC set up advocacy database on all local advocates who would then be available for employment opportunities.

## C Workshop: Performance Management, Accountability and Ethnic Monitoring (Nov 2002)

**PEOPLE IN ATTENDANCE:**

| | |
|---|---|
| Yildiz Biray | K&C PCT |
| Judith Blakeman | KCW CHC |
| Dan Brown | Westminster PCT |
| Aisling Byrne | BME Health Forum |
| Sue Cooper | Westminster PCT |
| Bridget Davies | Minutes |
| Renee de la Haye | K&C PCT |
| Yohannes Fassil | KCW PCT |
| Kitty Fitzherbert | Westminster PCT |
| James Fitzpatrick | Westminster PCT |
| Jackie Grant | St. Mungo's |
| Vicki Hazelton | K&C PCT |
| Jason Ireland | Westminster PCT |
| Gareth Jones | CNWL MH Trust |
| Jennie Mussard | Westminster PCT |
| Catherine Philpott | Westminster PCT |
| Moreen Ramcharan | St. Mary's NHS Trust |
| Dr. Michael Soljak | NW London HAS |
| Graham Straughair | Chelsea & Westminster Hospital |
| Jeremy Walding | Bromley PCT |

The meeting was chaired by Yohannes Fassil, who explained the purpose of the workshop:

- to assess the current situation in place around systems to monitor the progress of race equality schemes and London Planning and Parity Guidance 2002 targets and milestones. All NHS Organizations should have a plan of action to record ethnic coding and achieve 95% completion rate in acute and mental health by April 2003.
- to share information and good practice, patient profiling in primary care and to complement work on broader ethnic group data and create a network, formal and informal, on ethnicity and equality group work to share resources in KCW and across the sector.

It was a follow-up of the June 2002 workshop of the Race Equality Partnership Group in view of the need to share resources in KCW and across the sector. All Public bodies are expected to set up systems to monitor progress of their race equality strategy and action plan year by year and review the scheme every three years.

Presentations were made by the following people:

1. Dan Brown information analyst at Westminster PCT - Ethnic coding in hospitals and mental health
2. Jason Ireland, Westminster PCT - Ethnic coding in Community Health Service (CIS)
3. James Fitzpatrick from IT shared services – K&C and Westminster PCTs
4. Dr. Michael Soljak from NW London Strategic Health Authority - Improved data for chronic disease management in primary care

The second part of the workshop was a group discussion that produced the following action points:

- PCTs should have regional ethnicity targets.

- At first there was no particular level of coding in primary care; but this was improving.
- GP practices should start collecting patient profiling data. In Westminster 50% of GP practices have introduced patient profiling.
- The 2001 census should be a guide
- Support varies widely within PCTs.
- Best practice and co-ordination are needed in the whole sector; e.g. a common register for chronic mental illness.
- A good quality ethnic coding could help to assess the lack of referral by GPs of refugees and asylum-seekers to hospitals and specialists.
- Gareth Jones pointed out the distinction between ethnic recording and ethnic monitoring and the essential need to know what the figures from recording meant. Computer systems must enable comparisons to be made, and the quality of data should be examined. All race equality schemes were published, with clear action points and milestones. It is important that there is a system in place to monitor progress against the targets.
- NHS Trusts and PCTs are required to make the progress report public.
- The Strategic Health Authority has set up a race equality monitoring group to co-ordinate action.
- It was agreed to establish a standard sub-classification of the major ethnic groups in KCW and even across North West London. The Strategic Health Authority should facilitate the development and consultation of sub-category.
- Information from the 2001 census was deficient; thousands of people in KCW have not been enumerated.
- Imperial College was doing an ethnic survey for Westminster.
- Gareth Jones suggested more reliance on self-definition.
- Improvement was needed in terms of recording community services.
- Aisling Byrne recommended inclusion of good practice stories, to encourage others to enter data; and making the method of ethnic monitoring part of staff induction.
- Gareth Jones said the aim was to identify institutional racism and eliminate unlawful discrimination: in this field much could be done, apart from collection of data.
- It was agreed that there should be a link between the ethnic monitoring group and the Data Quality Group.
- PALS and NHS direct to collect ethnic code of users to monitor the uptake of the services.

## D Partnership Working (December 2002)

This meeting had been organized as part of the BME Health Forum's regular quarterly meeting.

**PEOPLE IN ATTENDANCE**

| | |
|---|---|
| Taheera Aanchawan | Organisational Development Consultant |
| Sue Arnold | NW London NHS WDC |
| Henry Bewley | RBK&C |
| Judith Blakeman | KCW CHC |
| Aisling Byrne | BME Health Forum |
| Joan Chakaodza | Lighthouse West London |
| Zakia Chentouf | Al Hasaniya |
| Bridget Davies | Minutes |
| Andy Denton | KCW CHC |
| Karen Drennan | KCW CHC |
| Tim Ellis | RBK&C Social Services |
| Yohannes Fassil | K&C & Westminster PCT |

| Name | Organisation |
|---|---|
| Anne Foster | K&C PCT |
| Kate French | Consultant |
| Joan Gould | K&C Advocacy Alliance |
| Jackie Grant | St. Mungo's |
| Renee de la Haye | K&C PCT |
| Katija Huijbers | MRCF |
| Patrizia Lorefice | African People's Link |
| Cecilia Ndola-Myers | KCW CHC |
| Liz Potter | RBK&C Adult Protection |
| Wendy Simpson | Havengrove |
| Nick Tittle | K&C Community Safety |
| Colleen Williams | Westminster City Council |
| Yohannes Fassil | K&C & Westminster PCT |


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Aisling Byrne explained that the present meeting was set out in café style and that the workshop would be held along the lines of a Café Process – for information on this process see: www.theworldcafe.com.

Kate French introduced the concept of **Partnership Working**. Currently it was popular to set up networks and partnerships, but there was a risk of there being too many, duplication, and sometimes lack of strategy. An earlier generation was brought up to think change could be planned; but this was now considered no to be workable – and partnerships could not be planned. Nor could change be controlled or directed, since it was not effectively linear. Instead of a person giving orders or directions, change could be brought about through networks, partnerships and the formulation of simple rules or principles.

Listening to the ideas of others was challenging, and it was good to recognize diversity in the partnership or network model, leading to creativity. People should have the power to be innovative.

The power of a small group, as against that of a large, dominating group, lay in being in touch with the community and knowing its business. Being highly flexible and responsible to changes was good for lobbying and campaigning. The notion of power needed to be considered in networks; and the notion of trust was hugely important. Motives for collaboration needed thought (would there be better outcomes?), and the pre-networking phase was crucial to generate motivation. It was quite usual for partnerships to form, dissolve and reform differently.

Yohannes observed that leadership had to come from the stakeholders, and to be organized so that jobs were done and meetings called – but without a sense of command and control. If partnerships were to work, they needed time to grow and be defined.

Colleen defined partnerships and networks as having different functions and not being interchangeable.

## 1. Points That Emerged from Discussion Around *"What Are the Principles of Good Partnership?"*

- Open-ness and transparency
- Equity
- Flexibility in the approach to work
- Common agreement and shared values
- A clear agenda and terms of reference
- A sense of role and purpose
- Respect for organizations
- Trust
- Regular contact with partners
- Understanding of the processes
- Users should be central to the process
- Sustainability
- Ability to listen to comments from all levels
- Best possible use of working time
- Recognition of cultural needs
- Mapping of what is already happening

## 2. In the Light of the Discussions, "What Changes Would You Like To See?"

- Better consultation with users
- The speed of movement makes consultation difficult – improve on this
- Mapping, to find out what's good and what's not so good.
- Determine expectations at the outset – be realistic
- Meetings are the basic tool – it needs skill to run a meeting
- Training, to learn new methods
- More involvement by chief executives, etc.
- Councillors need diversity training and better understanding
- Use tensions to own advantage
- Development of core principles and how to action them
- Better communication and information systems
- A structure that allows input and team working
- Training in collaborative working, for everyone
- Reduce bureaucracy, flatten hierarchy
- Money to allow small groups/users to participate
- Serious horse-trading between agencies
- Government to allow partnerships to set their own agenda
- Adequate resources – financial/time/training
- Long-term funding
- Understanding the systems, culture and politics of partner organizations
- Clarification of roles
- Identify 'hard to reach' groups
- Value personal relationships – linking people
- Try and even the relationship so that it's not 'them and us'
- Be more reliant on good systems and less on good people
- Adopt a pragmatic approach

## 3. Comments were invited on the café method, and contributions were as follows:

- The interaction and moving around led to good conversations.

- It was good for generating ideas, but not structured to achieve results
- It was good for networking, and as a change from workshops
- The method energized, encouraged and provided support
- The initial three minutes silence gave time for thought
- It was possible to talk with a feeling of anonymity
- Moving around helped participants re-engage and refresh their ideas
- One participant disliked the concept, especially if she felt she had nothing to contribute.

## Appendix 1:
## PEOPLE WHO ATTENDED 26 June 2002 WORKSHOP:

| Name | Organisation |
|---|---|
| Dr. Alexander | MRCF Health Advocacy Course |
| Ahmed Ali | Somali Parents/Childrens' Assoc. |
| Omer Altarpes | MRCF Health Advocacy Course |
| Joyce Appoh | African Joy Organisation |
| Kiki Aryeetey | MRCF Health Advocacy Course |
| Simon de Banya | CRE |
| H. Barbary | Egyptian Community Centre |
| Mark Beauchamp | RBK&C Corporate Services |
| Nasrullah Ben Omar | Refugee Clinical Team |
| Samira Ben Omar | BME Health Forum |
| Sandla Bhaja | Peabody Trust |
| Yildiz Biray | K&C PCT |
| George Bishop | RBK&C |
| Judith Blakeman | KCW CHC |
| Jackie Cambridge | Westminster PCT |
| Yandine Celque | MRCF Health Advocacy Course |
| Mary Cleary | K&C PCT |
| Mary Collins | St. Mary's NHS Trust |
| Miriam Colque | MRCF Health Advocacy Course |
| Sarah Corlett | CRE |
| Lorraine Coubert | Dalgarno SRB Partnership |
| Bernhard Crede | K&C PCT |
| Bridget Davies | Minutes |
| Cathy Davies | City of Westminster College |
| Andy Denton | KCW CHC |
| Karen Drennan | KCW CHC |
| Yohannes Fassil | Westminster PCT |
| Gosaye Fida | Westminster PCT |
| Zufan Gebray | MRCF Health Advocacy Course |
| Gary Gordon | MRCF Health Advocacy Course |
| Loraine Gravesande | Westminster PCT |
| Paul Haigh | K&C PCT |
| Amanda Harrington | Chelsea & Westminster NHS Trust |
| Renee de la Haye | K&C PCT |
| Katija Huijbers | MRCF |
| Papia Hussain | Westminster PCT & AMWA |
| Elcena Jeffers | Black Disabled People's Assoc. |
| Charleen Johnashew | Kensington & Chelsea College |
| Gareth Jones | CNWL Mental Health Trust |
| John Kelly | HJT Human Rights Team |
| Barivan Kitjani | MRCF Health Advocacy Course |
| Verna Lyons | Kensington & Chelsea College |
| N. Mohamed | MRCF Advocacy Course |
| Bruce Morris | CNWL Mental Health Trust |
| Carmen Munoz | Westminster PCT |
| Cecilia Ndola-Myers | KCW CHC |
| Maryana Obeid | Sure Start, N. Kensington |
| Antone Ogosa | Uganda Youth Support Group |
| Jean-Luc Revest | Mental Health Advocate |
| Susana Rubio | Sure Start, N. Kensington |
| Ruth Runciman | CNWL Mental Health Trust |
| Jorge Salgado-Rocha | K&C Social Council |
| Jonathan Sampson | St. Mary's NHS Trust |
| Diana Scott | Westminster PCT |
| Sena Shah | RBK&C Social Services |
| Jo Shim | KCW CHC |
| Wendy Simpson | Havengrove |
| Anne Smith | Sixty Plus |

| | |
|---|---|
| Aranos Teclehaimanot | 50 Plus Elderly Eritrean Assoc. |
| Nick Tittle | K&C Community Safety Team |
| Daren Townsend | Westminster City Council |
| Anne Wadey | St. Mary's NHS Trust |
| Janet Yilkes | MRCF Health Advocacy Course |
| Jan Yorston | Common Ground/PDT |
| Assiya Yousef` | Yemeni Community Association. |

APOLOGIES:

| | |
|---|---|
| Cllr. Robert Atkinson | RBK&C |
| Zrinka Bralo | MRCF |
| Tim Ellis | RBK&C |
| Vicky Grosser | Westminster DV Forum |
| Sabiha Menon | Westminster City Council |
| Emma Richardson | K&C Social Council |
| Similola Towry-Coker | Notting Hill Social Council |
| Peter West | RBK&C |
| Colleen Williams | Westminster City Council |

APPENDIX 2:
Strategic Policy Framework
Sarah Corlett, Health Strategy Initiative, CRE/Dept of Health

## Community Involvement in Race Equality Schemes

## The Strategic Policy Framework

### The Context (1)
### The Stephen Lawrence Inquiry Report

Report identified institutional racism and highlighted

- stereotyping
- colour and cultural blindness
- failure to implement policy
- lack of sustained leadership
- communities' loss of faith in the system
- the need for public services to rebuild trust
- the need for public services to demonstrate fairness

### The Context (2)
### Government response

- Commitment to aims of
  - Removing *potential* for discrimination in the public sector
  - Ensuring public authorities build race equality into all aspects of their public services
- To amend the Race Relations Act giving statutory General Duty to public authorities to promote race equality
- Promote openness and accountability as means to improving performance within modernisation agenda

## The Race Relations (Amendment) Act 2000

## General and the Specific Duties

### The General Duty

Public authorities in carrying out their functions shall have *due regard* to the need to

- Eliminate unlawful racial discrimination
- Promote equality of opportunity
- Promote good race relations between people of different racial groups

### The Specific Duties

- Prepare and publish a Race Equality Scheme
- Assess which functions/ policies are relevant
- Arrange to monitor adverse impact
- Arrange to assess and consult on impact
- Arrange to publish results
- Arrange to provide access to information
- Arrange for staff training
- Implement measures to monitor and reduce race discrimination in employment

## Partnership, consultation, user participation

- Central to the delivery of the General and Specific Duties
- Effective
  - Needs assessment
  - Impact assessment
  - Monitoring
  - Service design
  - Service delivery

**all** require active community and user participation

## Partnership, consultation, user participation

To be effective this needs

- Understandable, open and accountable processes
- Regular arrangements not a series of "one-offs"
- Wide dissemination of arrangements using various media
- Integral to mainstream business not last minute "bolt on"
- Initiatives to broaden external input not reliance on last year's address list
- Coordination across local partnership

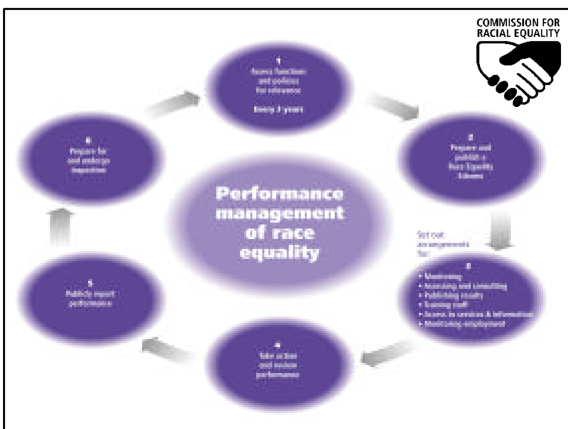
## Partnership, consultation, user participation

- Accessible relevant information so people participate on equal footing and make informed contribution
- Community organisations have capacity to represent & advocate effectively
- Service provider role of ethnic minority community organisations enabled and supported
- Range of public bodies in a community partnership: local authority, learning & skills councils, police, health

## Community involvement in Race Equality Schemes

- Race Equality Schemes set out the means; not an end point.
- 31st May was the *beginning* of a process of
  - consultation
  - monitoring
  - review
  - revision

to improve effective delivery and equality in public services




## The role of The Commission for Racial Equality

- To encourage, share and demonstrate good practice
- To work in partnership
- To give practical advice and guidance
- To advise on training
- To publish statutory Codes and non-statutory guides
- To monitor trends in public sector practice
- To enforce the law

## Enforcement

- The CRE can conduct Formal Investigations
- The General Duty is enforceable through judicial review brought by CRE or another party
- The CRE can enforce any breach of the specific duties
- The CRE can issue compliance notices
- Public authorities have 28 days to respond to a notice
- After three months, the CRE can apply for a court order to make an authority comply with the notice
- A public authority can be found in contempt of court if it breaches a court order

## Monitoring Race Equality Schemes

- Inspectorates will inspect for race equality based on the General and Specific Duties
- Inspection regimes will also inspect for race equality outcomes
- Through the accountability mechanisms in the NHS eg. via strategic health authorities
- Race Equality Schemes are public documents and open to public scrutiny

## Summary

- Race Equality Schemes are the beginning not the end
- Consultation means active participation at every stage
- Demonstrating progress will be central
- Local coordination essential
- Public sector must use own accountability mechanisms to monitor
- CRE will balance partnership and support with enforcement