

Still A Fair Way To Go?

A Discussion Paper

Prepared by the Black Leadership Network
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*Fair For All
2002*

*Race Relations
(Amendment) Act
2000*

*Race Relations
Act 1976*

BLN
Black Leadership Network

NHS
Health
Scotland

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Foreword

The pursuit of assessing progress and tracking change in Race Equality in NHS Scotland has been ongoing for some time. Since the inception of the Fair for All policy in 2002, the National Resource Centre for Ethnic Minority Health (NRCEMH) led an integrated assessment framework in partnership with the Commission for Racial Equality. This was then followed by the Fair Enough? Review in 2003. As NHS Boards review and prepare their revised race equality schemes at the end of 2008, it is timely to consider the *impact* of work to address race equality since Fair Enough? and, if progress is less than had been hoped, to learn from this and understand better what barriers are faced by NHS Boards and how these can be overcome.

The Directorate of Equalities and Planning at NHS Health Scotland was established on 1 April 2008 to build on the work of the previous Fair for All projects, including NRCEMH, and to take the lead in supporting NHS Boards to make further and lasting change in equalities practice. Given the requirement on all Boards to review their race equality schemes by November 2008, it seemed very fitting that one of the first major projects commissioned by the Directorate would be to support Boards in this review.

Through the consultation process that led up to the establishment of the Directorate of Equalities and Planning, there were two recurrent themes – the wish to continue in the spirit of partnership working across all Boards involved in this agenda and the recognition that real and active engagement with communities was a priority for development. In considering how to take this work forward, it therefore seemed obvious that the most appropriate people to tell us if there was evidence of real change would be individuals from the Black / Minority Ethnic (BME) communities themselves and that, in our position of national support as a Directorate, we could facilitate this expertise being made available to all NHS Boards who wanted to benefit from this opportunity of working in close partnership with each other and with the BME community.

We are delighted therefore that we were able to identify, through the Black Leadership Network (BLN), a group of BME health professionals who have brought enormous levels of skill and expertise to this agenda in order to help us move forward together.

The approach has been to ask BME community partners to act as peer reviewers, offering supporting and reflective learning to Boards in order to both identify the current barriers to progress as well as jointly work towards long term solutions. We have started by developing a national overview of progress across the 22 health Boards, which is presented in this discussion document. At the same time, we have identified six volunteer Boards who wish to take part in an extended process of in-depth peer review over a six-month period. At the end of that period, we will report again on the findings and learning from that review process.

However, we believe that the overview report itself has identified a wealth of issues that merit further examination, consultation and debate and we would like this first report to act as a catalyst for dialogue, discussion and feedback from health service staff and users of the health service over the next four months. This will lead ultimately to a formal roundup of this whole review project in March next year.

We anticipate that the conclusions from that review will inspire Boards individually to achieve further and faster progress with race equality and also give pointers to the new Mutuality, Equality and Human Rights Board on priorities for the NHS overall in achieving real change in both race equality and the whole equality and human rights agenda.

Cath Denholm
Director of Equalities and Planning
NHS Health Scotland

1. Introduction

1.1 The Black Leadership Network (BLN) was established in January 2006 by the Council of Ethnic Minority Voluntary Sector Organisations in Scotland (CEMVO Scotland) and the Glasgow Anti Racist Alliance (GARA) to develop a collective leadership agenda amongst Black / Minority Ethnic managers in addressing Race Equality in Scotland. Integral to this is the need to challenge institutional racism as defined by the Macpherson Inquiry into the murder of Stephen Lawrence:

“The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage Minority Ethnic people”¹

1.2 The Network currently has a membership of over 50 Black / Minority Ethnic (BME) managers from the voluntary and public sectors throughout Scotland, many of them working in health-related organisations.

As such, a useful dialogue has been established between the Network and the new Equalities and Planning Directorate within NHS Health Scotland, and both sides are keen to develop effective models of partnership working at a strategic level.

1.3 In particular, it is acknowledged that whilst the NHS in Scotland can be proud in terms of its achievements in making health services fairer and more accessible to everyone who uses them and works in delivering them, there is still much more to be done. Central to this is a widespread perception that not enough evidence of ‘change’ or ‘change’ itself has been experienced on the ground by BME communities. Indeed, the recently launched report of a ministerial task force, Equally Well² stated that ‘(addressing) health inequalities remain our major challenge’.

1.4 In terms of promoting anti-racism, achieving racial equality and eliminating discrimination, there is a need to ensure that the successes of the former National Resource Centre for Ethnic Minority Health (NRCEMH) are not lost and that the legacy of Fair For All³ (FFA) continues. More specifically, we assert that the work that needs to be undertaken over the next weeks and months includes:

¹ The Stephen Lawrence Inquiry, The Stationery Office, 1999 (para 6.32, page 28)

² Equally Well - Report of the Ministerial Task Force on Health Inequalities, May 2008, Scottish Government

³ Fair For All, Scottish Executive 2001, also SEHD HDL (2002) 51

- reviewing of progress of current / previous Race Equality Schemes in NHS Boards (and race components of single equality schemes where appropriate)
- developing more effective race equality schemes for the period 2008 / 2011, ensuring the effective mainstreaming of race equality into NHS Scotland
- ensuring meaningful race equality impact assessments are carried out on all new policies and procedures
- reviewing availability of race specific health data and developing an action plan to fill information gaps identified
- assessing performance and ensuring greater accountability back to the Black / Minority Ethnic voluntary sector and to BME service users
- building on the skills of existing staff in the Directorate and of members of the Equality and Diversity Network and developing enhanced models of partnership working between NHS Health Scotland, Boards and Black / Minority Ethnic communities in Scotland
- addressing issues of under-representation in the NHS workforce in Scotland, including retention and promotion of BME staff
- examining and addressing race equality issues in relation to procurement
- working to inform national policy and strategy that will improve current processes and NHS capacity for delivery of tangible and measurable outcomes in health improvement and reduction of inequalities for BME people
- addressing how the requirement to promote good race relations within the work of NHS Scotland can be measured in terms of outcomes and real progress
- assessing how the emerging human rights agenda will impact on the work of NHS Scotland and working to develop a rights based culture throughout the NHS in Scotland

1.5 The Black Leadership Network believes that these are all areas where the expertise and experience of members of the BLN can be utilised to assist NHS Health Scotland in delivering measurable change.

1.6 However, for this input from BLN to be meaningful, it was felt that the usual means of ad-hoc meetings would not suffice. It was therefore proposed

that a formal consultancy arrangement be agreed between NHS Health Scotland and the BLN which would result in BLN facilitating the release of some of its members to provide dedicated input into this work.

1.7 Recommendation 73 from Equally Well states that:

“The Government should work with existing and new expert organisations in Scotland to develop a wide range of approaches to outcome and impact evaluation.”⁴

We believe that our proposal is one way in implementing this call.

1.8 The focus of the input of the BLN would be an overview on relevant issues for NHS Health Scotland and for all 22 individual Boards. The outcome would be a general, overall picture of race equality progress in a summary report covering a brief desktop analysis of the 2005/08 race equality schemes of all 22 NHS Boards in Scotland. Given we are near the end of this period, this work would be largely retrospective and reflect the common issues raised through an overview of all schemes, hopefully providing useful information that could be used by Boards, both in reviewing issues relating to their own reviews of their schemes and in progressing their future racial equality work.

1.9 In addition, once the national overview was completed, six (self-selecting) Boards would be identified and expert support and guidance would be provided to these. We would hope that much of this work could then be easily replicated to the other Boards across Scotland.

1.10 The strengths and uniqueness of the BLN proposal include:

- proper NHS accountability of the NHS to Black / Minority Ethnic communities and the BME voluntary sector, through people already trusted in terms of dealing with / delivering health-related services to BME communities in Scotland;
- longer term sustainability, ownership and responsibility (as opposed to using a one-off external consultant);
- the indirect provision of capacity-building of the BME voluntary sector in terms of paying for skills, knowledge and experience;
- external overview of the lessons to be learned from the 2005/08 race equality schemes, from practitioners' perspectives;

⁴ Equally Well - Report of the Ministerial Task Force on Health Inequalities, May 2008, Scottish Government

- detailed provision of support and guidance to NHS Boards;
- input and guidance on improving the collection and usage of data on ethnicity and health;
- improved community engagement;
- measurable change, evidenced through regular reviews between the Equalities and Planning Directorate and BLN.

1.11 This is an innovative and new way of working, with regular reviews built in to ensure effective delivery of agreed outcomes. If successful, it could be replicated for other equality strands, and indeed, other areas of public service.

1.12 However, whilst previous efforts have had their successes, not enough change has been embedded in policy and practice to satisfy the legal requirements, let alone the needs and wishes of the BME communities in Scotland. Indeed, we hope the NHS shares with us the need to go well beyond the basic legal requirements and build a truly anti-racist health service for Scotland.

1.13 The BLN proposal is made by people who have already shown their commitment to and expertise in the issues at hand and we are sure that joint working between BLN and NHS Health Scotland on an equitable basis can go a long way in terms of delivering the change that we all want to see.

2. The Legislative and Policy Context

The work of NHS Scotland and its constituent Boards is underpinned by three key pieces of race / equality legislation. These are the Race Relations Act (1976), the Race Relations (Amendment) Act 2000 and the Human Rights Act (1998).

2.1 The Race Relations Act 1976

The Race Relations Act is the primary legislation covering race discrimination in Great Britain. It replaced and expanded the coverage of the original 1968 Act and applies to all public and private premises, local authorities, the NHS, the Police, governmental institutions, the voluntary sector and private providers of services, public houses, clubs and restaurants.

The Act made it unlawful to discriminate on the basis of race in employment, training and related matters, education, and in the provision of goods, services and facilities. This Act also distinguished between direct and indirect forms of racial discrimination.

2.2 The Race Relations (Amendment) Act 2000

The Amendment Act was introduced in the light of the findings of the Macpherson Report⁵ and its definition of institutional racism. It both expanded and strengthened the powers of the 1976 Act and placed a requirement on all Public Bodies to consider their activities with regard to the:

- Elimination of unlawful discrimination;
- Promotion of equality of opportunity; and,
- Promotion of good race relations between people of different racial groups.

These are collectively known as the General Duty.

All listed Public Bodies were also required to comply with the Specific Duty by developing and publishing a Race Equality Scheme. The Scheme must state in full what functions and policies it has assessed as being relevant to race equality and its arrangements for:

- Assessing and consulting on the likely impact of policy on race equality;
- Monitoring its policies for adverse impact;
- Publishing the results of its assessments, consultations and monitoring;

⁵ The Stephen Lawrence Inquiry, The Stationery Office, 1999

- Ensuring public access to information and services;
- Training its staff in the new Duty; and,
- Reviewing its progress every 3 years.

2.3 The Human Rights Act 1998

The Human Rights Act 1998 made rights from the European Commission on Human Rights (the Convention Rights) enforceable in British courts. In particular, Article 14 of the Convention on the Prohibition of Discrimination states that 'The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status'.

Policy Drivers

2.4 Fair for All (2001)

Fair for All⁶ identifies five key elements which Health Boards are required to take forward in working towards a culturally competent service. These five deliverables are:

- Energising the organisation (Statement of Organisational Intent, Executive Leadership, Action Plan);
- Demographic Profile (Surveying the Local Population, Health Needs Assessments, Commitment to Research);
- Access and Service Delivery (Access Audit, Personal Care, Food, Spiritual Care, Translation and Interpretation, Advocacy, Gender Issues, Bereavement);
- Human Resources (Equal Opportunities, Improvement Policies, Bullying and Harassment); and
- Community Development (Collaborative Mechanisms, Developing the Community).

2.5 Fair Enough? (2003)

Fair Enough?⁷ was commissioned jointly by the National Resource Centre for Ethnic Minority Health and the Commission for Racial Equality. It reported on a desk-based analysis of race equality schemes and Fair for All action plans

⁶ Fair For All, Scottish Executive 2001

⁷ Fair Enough? Fair for All Progress Report: Analysis of Race Equality Schemes & Fair for All Action Plans, Scottish Executive, 2003

produced by all Scottish Health Boards and Trusts in response to their (new) responsibilities under the Race Relations (Amendment) Act.

2.6 Better Together: Scotland's Patient Experience Programme (2008)

The Better Together: Scotland's Patient Experience Programme will co-ordinate feedback into how patients find their experience of treatment within the NHS in Scotland. Feedback from 250,000 patients annually will be disaggregated by age, disability, gender, race, sexual orientation and religion or belief and will be used to develop national improvements in services.

2.7 Equally Well (2008)

Equally Well⁸ contains a number of key recommendations with particular relevance to race equality:

- NHS Boards should take opportunities to play a leadership role in promoting good relations within communities recognising the impact of discrimination and disadvantage on health (recommendation 62);
- All contractors and providers commissioned by the NHS should be explicitly required to monitor their services in accordance with public sector equality duties, ensuring that their analysis uses qualitative and quantitative data to monitor the needs of different groups (recommendation 63); and,
- NHS Health Scotland should deliver an accessible communication, translation and interpreting strategy and action plan, with clear outcome measures (recommendation 64).

In particular, in recommendation 2, the report stated 'that those responsible for implementing task force recommendations should carry out equality impact assessments on the action they are taking to ensure this is legally compliant; systematically consider the needs of the diversity of the population; ensure action does not adversely affect any part of the population; and consider how they can promote equality'.

⁸ Equally Well - Report of the Ministerial Task Force on Health Inequalities, May 2008, Scottish Government

3. Key Findings

3.1 The findings below are based almost exclusively on a desktop analysis of the 22 Boards' 2005/08 race equality schemes and associated paperwork as supplied to the BLN in response to a questionnaire (see Appendix). In a small number of cases, the findings have been enhanced by a review of documentation available from the websites of particular Boards, and also through the on-going face-to-face discussions that are being held with the six Boards (NHS Health Scotland, Scottish Ambulance Service, NHS Borders, NHS Fife, NHS Lothian and NHS Shetland).

3.2 An evaluation template, based on CRE guidance and FFA themes, was adapted by the BLN for this exercise. Each race equality scheme (RES) was evaluated via this template and common themes emerging from this exercise were identified and are reported below.

3.3 The aim of this initial overview was not to give detailed analysis of each race equality scheme. This level of detail will be provided via the work that is on-going with the six self selected Boards and it is hoped that many of lessons to be learned through this exercise will be disseminated to and be applicable to many other Boards. The overview is geared towards identifying common themes that need to be addressed by the NHS in Scotland.

3.4 As a largely paper exercise, the only evidence that BLN had of the Boards' performance was through the documentation supplied. The findings below are an indication of where additional work is considered necessary to improve policy and practice to enable the NHS to better meet the requirements of the Race Relations Act 1976 as amended by the 2000 Amendment Act. It should not be seen as an overall assessment of how well or not the NHS in Scotland overall is performing in promoting equality, challenging discrimination or promoting good race relations.

3.5 The report also does not identify any specific Board to highlight any example of bad or good practice. Consequently, we have not quantified the numbers or percentages of Boards that meet or do not meet any particular criteria. **The findings provided below should not be seen to be necessarily applicable to all Boards**, and we accept that a number of Boards may well feel that many of the findings are not applicable to them. Nonetheless, our overall analysis is that no Board can say it is fully compliant with the legislation and every Board will have at least some areas where further improvements are necessary.

3.6 Additionally, there is evidence (especially through the face-to-face meetings that we have already held) that a number of schemes do not properly reflect the full extent of the work they have and are carrying out in meeting the requirements of the Act. Therefore, we accept that this report may not fully reflect the actual position vis-à-vis actual current practice (and this was another reason for not reporting on numbers or percentages).

3.7 The assessments were on the 2005/08 schemes and therefore the exercise has been largely retrospective. We assume and hope that much has progressed in the years since some of the schemes were published. However, we have had sight of only a very small number of annual progress reports, even though schemes have committed their respective Boards to publish these.

3.8 Our overall findings are loosely grouped around the five FFA thematic headings:

- Energising the organisation;
- Demographic Profile;
- Access and Service Delivery;
- Human Resources; and
- Community Development.

3.9 Finally, we have chosen not to end the report with a series of recommendations. We did not feel that this would be the most productive way forward, as there are already many many recommendations of previous exercises that have yet to be implemented. In particular, the Fair Enough? Fair for All Progress Report⁹ published in 2003 made fifty recommendations, many of which we could have almost exactly duplicated in this exercise. A copy of the 2003 recommendations is provided in Appendix B of this report. The real question to be asked is why have many of these findings, now over five years old, still not been implemented.

3.10 We are therefore publishing our findings and thoughts as a Discussion Paper. We believe that this will be a more meaningful and productive exercise, leading to a greater understanding and ownership of the issues involved throughout the NHS in Scotland and help progress making racial equality a reality in the years to come.

⁹ Fair Enough? Fair for All Progress Report: Analysis of Race Equality Schemes & Fair for All Action Plans, Scottish Executive, 2003

4. Energising the Organisation –

4.1 Understanding of Racism – We argue that without properly understanding racism it is almost impossible to properly deliver on the general duty contained in the Act. There are some Boards that still see the writing and implementing of the race equality schemes as an exercise in managerial expediency as opposed to a tool to be used in challenging oppression and discrimination. Whilst some Boards demonstrated a level of the understanding necessary, many schemes did not seem to have a real appreciation of why the UK Parliament amended the Race Relations Act 1976 and placed specific and general duties on all public sector bodies. Explicit anti-racist perspectives are needed as opposed to focusing on race awareness and / or enhanced services to black communities. Such perspectives should form an integral part of both new and existing training programmes for NHS staff.

4.2 The issue of Institutional Racism is also important here – many schemes did not reflect a proper understanding of its meaning and manifestation, and without this understanding we would argue it becomes almost impossible to address.

4.3 Leadership – In line with the managerial expediency mentioned above, most schemes explicitly state that there is executive leadership on this issue within their Board. However, real evidence of this has been hard to find. For example, many schemes mention that their Board Chair and Chief Executive had signed up to the CRE Leadership Challenge in the early 2000's but there was little evidence of what this meant in practice. The role that individual Board members and Boards collectively have on this issue needs better defining.

4.4 Ownership of Schemes – We found it hard to judge the extent to which the schemes were actually 'owned' by the organisation, its executive and non-executive management, and its entire staff. Too often, it seems that Human Resource personnel were allocated to lead on the scheme even though HR issues form a small part of the issues covered via the scheme.

4.5 Statement of Intent – While most Boards articulated strong positions regarding their commitment to equality and diversity in their Schemes, there was a certain formulaic approach in content and presentation which could be mistaken for a tokenistic interpretation of the duties and subsequent proposed responses to either Fair for All or the Race Relations (Amendment) Act 2000. At best, defining the letter of the legal obligation created dry, dispassionate commitments, disconnected from the daily realities of individuals living with discrimination and racial prejudice.

4.6 Collaboration with Others – Whilst some Boards evidenced significant joint working, not only in developing the scheme, but also on day-to-day operations and on reviews of the action plans, (including with community planning partners), others made no mention of any liaison with others. Given that there is a wealth of expertise in Scotland specifically on race and health issues, we found this surprising.

4.7 Mainstreaming and Promoting Good Race Relations – We found little real mention of how race equality issues would be mainstreamed into the body of the NHS in Scotland. This has added to views that the development of race equality schemes is just an exercise in how to assist Black / Minority Ethnic people. Additionally, schemes did not adequately address issues of institutional racism within the NHS. Similarly, much more thought needs to go into the role of the NHS in strand three of the duty, promoting good race relations.

4.8 Action Plans – Action Plans have varied in many aspects, and they have not always incorporated SMART targets. In particular, some have lacked meaningful deadlines for specific actions and many have not identified the resources that would be required to implement the actions specified. Action Plans need to evidence actual change that is taking place on the ground, as opposed to emphasising indicators of activity or process. A good starting point would be to baseline the current position, but few schemes attempted to do this. Where FFA assessments have been carried out, it would be useful to link these to the action plans.

4.9 Publishing of Schemes – Schemes were not always easy to read or user friendly. Better layouts and use of diagrams, flowcharts and matrixes as used by some were thought to be useful. Where appropriate, a more consistent, standardised approach across the whole NHS in Scotland would be beneficial.

4.10 Reporting Progress - Whilst there is no legal obligation placed on Boards to provide an annual progress report on the RES, we strongly recommend that Boards seek to achieve parity on reporting with both the gender and disability duties. Annual progress reports provide both a means of evidencing progress both internally and externally and a practical solution to the collation of data to inform the three-year review. Central to the annual report must be evidence of what has ‘changed on the ground’ for BME communities. For example, has race equality training resulted in improved patient care and if so, can this be evidenced through patient satisfaction surveys. These reports could also be used to report on where initiatives have not been as successful as hoped, or indeed have been discontinued, along with the reasons why.

5. Demographic Profile –

5.1 Population Information – By and large, data from the 2001 Census was used to create a ‘local’ profile and many Boards acknowledged that this had limited use by 2005, let alone now in 2008. Some areas had updated the data by using local authority ward profiles, but more effort is needed to obtain current information on the populations served by the various Boards. Some national Boards broke down the population profile into smaller areas although it is not clear how this local information was then utilised to improve services.

5.2 Ethnic Monitoring of Service Users – It is acknowledged that much more work is required in this area: whether to improve monitoring means and technology or simply get the systems talking to each other. There is also the great debate still to be had on confidentiality and data protection versus the need for statistics that can influence change and redress inequalities. It is useful to note that the top priority for future ethnicity and health research from the Scottish Ethnicity and Health Research Strategy Working Group¹⁰ is the creation of a system that ensures consistent ethnic coding within Scotland’s generally excellent health information systems. The Working Group is calling on the Scottish Government to develop an action plan with the aim of ensuring that by 2013 at least 80% of people registered with the NHS have their ethnic identity recorded, achieving nearly 100% by 2018. This target could be easily achievable if, for example, a requirement to record ethnicity (and indeed other equality categories) was included in the contract for general practitioner services. However, it should be noted that ethnicity monitoring is not an end in itself and consideration should begin to be given to how patient information on ethnicity will be used to inform workforce and service planning.

5.3 Health Needs Assessments - Whilst many Boards have completed health needs assessments, some very detailed, further efforts could be made to ensure that the outcomes of these assessments are better reflected in the RES and FFA action plans.

5.4 Research into Needs – Few Boards made explicit mention of research they had conducted or were conducting on local needs, changes in local demographics and how future research is to be identified and prioritised. We accept that it could be argued that much of the research required should be conducted at a national level. However, there will be local situations and circumstances that would merit more localised research.

¹⁰ Health in our Multi-Ethnic Scotland – Future Research Priorities, Scottish Ethnicity and Health Research Strategy Working Group, NHS Health Scotland 2008

6. Access and Service Delivery –

6.1 Feedback on Previous Action – A number of schemes gave little or no evidence of the previous history of race equality activities that had been undertaken. It was therefore difficult to see a pattern of continuous improvement taking place. It was apparent that many actions contained in previous schemes had not been enacted, but very few reasons were forthcoming as to why this was the case.

6.2 Screening and Impact Assessments – Schemes mentioned use of equality impact assessment (EQIA) tools, especially as promoted by the Scottish Executive (as was). Little mention was made of Checking for Change¹¹, a guidance and audit framework / toolkit developed by NRCEMH to support health Boards in Scotland with making progress in terms of race equality outcomes for service users, communities and staff alike. However, in many cases, no updated information was given on what use any tools had been put to and what the outputs and outcomes of this exercise had been. There was no analysis given on how functions and policies were identified and prioritised and it seems that this particular ‘exercise’ was largely done by one or two senior staff members. Involvement of Black / Minority Ethnic communities in this process may well have come up with a different prioritisation, although initial investment to build the capacity of the communities to participate meaningfully may be required. Joint training of NHS staff and members of the Black / Minority Ethnic communities may prove more effective, as would joint work in undertaking equality impact assessments.

6.3 A number of Boards have conducted large numbers of rapid impact assessments, and whilst this is a good first stage, many Boards have not gone to the next level and carried out full impact assessments, even on the policies and functions they have ranked as high priority. Indeed, there seems some thinking that rapid impact assessments are all that are needed to be done. Overall, it was clear that Boards needed more support and guidance on this aspect of the RES. Only a handful of full impact assessments have been provided to the BLN team.

6.4 Procurement - Some schemes made no mention of procurement issues and few had anything specific to say about how Black / Minority Ethnic contractors might be supported and encouraged to bid for external contracts. We noted the conflict between national guidance that could result in limiting which contractors could be used as opposed to CRE guidance encouraging the involvement of small businesses.

¹¹ Checking for Change – A Building Blocks Approach to Race Equality in Health, NRCEMH, 2007

6.5 Translations and Interpretation – Whilst this was one area where almost every Board had made continuing progress and had practices and procedures in place for utilising translation and interpreting services as necessary, not all Boards had rigorous procedures for monitoring take up of such provision and therefore may find it difficult to justify either the format (medium) or the provision. Few if any had any quality assurance systems to assess the work of the individuals / agencies being used.

6.6 A number of Boards also highlighted the difficulties they had in sourcing appropriate materials for use with BME communities. It may be more effective to undertake a national exercise in setting best practice standards for quality assuring translators / interpreters and their work, and develop a national web library of translated materials. This would have the advantage of avoiding duplication and maximising resources.

7. Human Resources –

7.1 Monitoring – Many Boards had basic procedures in place for ethnic monitoring throughout the recruitment, selection and career progression process. However, most procedures were not fully compliant with the Equality Duty. Even for those with better developed procedures and practices, most were lacking any analysis of what the figures meant and what specific actions they would take to change things. Ethnicity monitoring of new recruits was proving more productive than compiling an overall picture of the existing workforce and there appears to be a resistance by many staff members to comply with the process. This is undoubtedly worrying as it is the same staff who will be called on to undertake ethnic monitoring of service users. In some places, categories used for ethnic monitoring were not standard Census categories and this will make comparison and analysis across Scotland more problematic.

7.2 There is a national issue regarding confidentiality and data protection that would benefit from further discussion within the NHS in Scotland and with the Information Commissioner and Equality and Human Rights Commission. The identification of ethnicity when numbers are very low may not be significantly relevant if there are no other personal identifiers such as department or work location.

7.3 Training – Some evidence was found of entrenched staff attitudes and of how difficult, if not impossible, it would be to change the attitudes of such people. One manifestation of this was shown through a reluctance to attend anti-racist training. The process conducted by the BLN did not allow for an analysis of the content of the actual training provided, but schemes demonstrated very little evidence that outcomes of attendance at training were being adequately monitored, e.g. what changed as a result of the training. We saw little reference that the process of staff supervision, appraisals and personal development plans alluded to the learning gained from attendance on anti-racist (or more general equality and diversity) training. Practice amongst Boards as to whether such training should be mandatory also differed. There was little evidence of the involvement of local BME groups or organisations in the design or delivery of training to staff.

7.4 Positive Action – Given the (very) low levels of Black / Minority Ethnic staff in the employ of many Boards, and the legal authorisation for a variety of positive action measures that can be taken to rectify this problem (stemming from the 1976 Act) we were surprised to see how little attention was given to even the most basic positive action initiatives by most schemes. Positive action could also be utilised to aid promotion of black / minority ethnic staff, but again we found little evidence of any such initiatives.

7.5 Support for Black Staff – Few measures for specific support that was being provided to Black staff were mentioned in the schemes (e.g. black staff forums or external mentors). This may be partly as a result of the low numbers of Black staff in many Boards, and a more coordinated support structure across the whole NHS in Scotland may produce ‘added value’ outcomes in staff retention and staff satisfaction statistics, while demonstrating a pro-active approach to race equality. It should be noted that although some Boards’ usage of ‘confidential contacts’ is a valid, staff-wide exercise, uptake by BME staff did not seem to be monitored for effectiveness, appropriateness or any other feedback. As it is, this method is unlikely to provide a safe enough opportunity for the average BME staff member to voice or share even the smallest concern.

7.6 Racial Harassment / Bullying – All Boards had policies and procedures in place for reporting and dealing with racial harassment and bullying issues. Overall, very few race issues were reported as having been raised. We feel that too often this is taken as confirmation that no such problems exist and little attention seems to have been given as to the appropriateness or otherwise of the procedures themselves.

8. Community Development –

8.1 Overall, this was the weakest theme from almost all schemes. It was apparent that Boards had little or no clear understanding of community development and how it was to fit within the overall corporate framework of organisational and service development. For the majority of Boards, the notion of community development was limited to community consultation and engagement. Whilst these are important elements it should be stressed that the underlying principles of community development are rooted in the ability of a community to:

- to influence change and exert control over the social, political and economic issues that affect their lives;
- challenge inequitable power relationships within society and promote the redistribution of wealth and resources in a more just and equitable fashion;
- engage in participative processes and structures which include and empower marginalised and excluded groups; and
- challenge the nature of the relationship between the users and providers of services.

8.2 Additionally, community development involves strategies which confront prejudice and discrimination on the basis of race, gender, faith, age, sexuality, disability, class and socio-economic status.

8.3 One area in which Boards could make a real contribution to community capacity building is through the involvement of Black / Minority Ethnic communities in conducting impact assessments. The provision of joint training for NHS staff involved in impact assessments and Black / Minority Ethnic individuals / organisations would foster more productive and mutually beneficial relationships. Such training could leave a lasting legacy within the communities / organisations and outcomes of impact assessments would be informed by actual lived experiences.

8.3 This clearly presents many challenges for Boards but as yet there is little evidence that Boards are willing to enter into discussions with Black / Minority Ethnic communities and organisations about the potential of community development approaches to achieve real change (and make community engagement really meaningful).

8.4 In some schemes, specific consultation mechanisms were not specified, and there seems to be a distinct lack of understanding of what exact role the NHS has in terms of community capacity building. The National Reference Forum was of course mentioned by the national Boards, but in some cases it seems to be the only specific community consultation mechanism specified. The limited capacity of the NRF and confusion of its exact remit are all issues that need addressing.

9. Areas for Discussion

9.1 Before continuing, we must stress again that none of the foregoing should be seen as applicable to all Boards. Boards are at different levels of development on different issues; although we would assume that no Board would state that they don't have further to go on at least some of the areas mentioned above.

9.2 Given the varied levels of progress across Scotland, and the similarity of issues faced by many Boards, is there more scope for collaborative working, and sharing of resources and expertise? What more does NHS Scotland need to do to bring this about?

9.3 Conversely, would this shared working further diminish any one Board's ownership of the issues at hand, and perhaps do little to further better understanding of racism and its effects and why achieving racial equality is a core objective of the National Health Service in Scotland?

9.4 We asserted in (4.1) above that a proper understanding of racism is essential to properly deliver on the general duty contained in the Race Relations (Amendment) Act 2000. How does the NHS incorporate such an understanding into its soul – its staff, its structure, its policies and practices and in its delivery of front-line services? In other words, how can the NHS in Scotland institutionalise racial equality and anti-racism? How can we turn paper based, box-ticking, and compliance led culture into a living breathing entity that has mainstreaming of racial equality as routine daily practice?

9.5 It has been argued that if the achievement of equality were a national target (HEAT or otherwise) then greater attention would be paid to ensuring measurable progress on a day-to-day basis. The argument contends that the NHS has a culture of targets, and people will often concentrate on meeting these as opposed to all other actions. Is this the best way of ensuring progress, or does this move away from a mainstreaming approach? If target(s) are to be set, what should these be?

9.6 Through this exercise, we have not uncovered anything new in terms of additional recommendations on what needs to be done. Indeed, it is one of the key reasons that we have decided not to add a further set of recommendations to add to the multitude that are already published.

9.7 The Fair Enough? Report was the last similar exercise to the work the BLN set out to do, and the 55 recommendations made in that study are almost all still of relevance five years after they were made. Many have still to be implemented across the board, and we make no apology for re-printing them in full (see Appendix 2). This begs the question of why such slow progress has been made in addressing the issues raised by Fair Enough? – E.g. were their recommendations not relevant, or the wrong ones, or was not enough priority or resources given to ensure their adoption? There are many other reports looking at the NHS with many other recommendations. What is stopping the NHS from implementing these?

9.8 Whilst we did not look at 2002/05 schemes in this study, it was hard to gauge progress on developments from one three-year period to the next. Is there a defensiveness to be open when initiatives have not been as successful as hoped, and / or are Boards at times being too ambitious in their expectations?

9.9 Where does the question of leadership and ownership fit into all of the above? Previous research¹² has shown how central and crucial the issue of leadership is for the achievement of racial equality. How do we ensure leadership and full ownership of these issues across the whole of the NHS in Scotland?

9.10 As cited in Section 8 above, the issue of community development was the weakest theme in almost all Schemes examined. What is the exact role of the NHS in Scotland in relation to community development and what specifically do we need to do to bring this about?

9.11 In a similar vein, more efforts need to be given to fulfil the requirements of the third strand of the duty, the promotion of good race relations between people of different racial groups. What does this exactly mean for the health service in Scotland?

9.12 In many cases, there was a lack of real partnership between the NHS and the Black / Minority Ethnic communities. What more can the Black / Minority Ethnic sector do to support the work of the NHS in Scotland and how can we build a genuine two-way relationship?

¹² E.g. The CRE Leadership Challenge, CRE 1997

9.13 Good, accurate and up-to-date information is crucial to ensuring the provision of appropriate services to all. What are the additional information and research needs of the NHS in Scotland and how can these be met?

9.14 It can be argued that ethnic monitoring of service users is a pre-requisite if we wish to show that there is full equality of opportunity and availability / accessibility of services to people from different ethnic groups. What is stopping us from monitoring the ethnicity of users of NHS services in Scotland? How can we change this?

9.15 It would have been thought that ethnic monitoring of NHS staff would be easier than monitoring service users. Yet, in some places we do not know the ethnicity of over 50% of the workforce. What is making some staff reluctant to provide details of their ethnicity and how can this be rectified?

9.16 There is general under-representation of Black / Minority Ethnic staff at almost all levels of the NHS in Scotland. What can (should) be done to change this? Parliament recognised that to bring about equality would require positive action measures to be adopted until a level playing field had been established. Why is there such a dearth of positive action initiatives in the NHS in Scotland and how can we change this? We need to ensure that we retain those Black / Minority Ethnic staff that we do appoint. What additional support structures do we need to establish to assist this?

9.17 The Race Relations (Amendment) Act 2000 called for race equality impact assessments of policies and procedures as one way of ensuring the mainstreaming of racial equality. To date, the success of this has been limited. What more needs to be done to make race equality impact assessments more meaningful and have a direct effect on policy and practice? Should the Scottish Government conduct full equality impact assessments on all its policies, etc. before asking NHS Boards to implement these?

9.18 Many of the issues highlighted above are applicable throughout the public sector in Scotland. How might the NHS work better with other public sector partners to achieve racial equality throughout Scotland? Are the Single Outcome Agreements a possible way forward?

9.19 The issues highlighted above and in the rest of the report are just some of the ones that further discussion and debate is required on.

Still a Fair Way to Go?

The vision of a culturally competent and anti-racist National Health Service in Scotland, which delivers its services and employment opportunities fairly among all of Scotland's citizens, is shared by many.

Much commitment and hard work has been invested by many to get NHS Scotland to where it is now, and much progress has been made over the past decade.

We believe that now is the right time, the right moment for change to take the final steps in delivering on the agenda.

We believe that many of the building blocks are already in place, and with continuing commitment and hard work, we can all deliver a National Health Service that meets the needs of all in Scotland.

The Black Leadership Network invites you to contribute your views on this paper by joining in on the discussion at:

<http://tinyurl.com/6ky2nv>

10. Appendices

10.1 Questionnaire Responses

Core policies/ practices as provided by 15 of 22 Boards

Document	Key Driver	In Place	Received with questionnaire or subsequently
Statement of Organisational Intent	FFA	15	8
Action Plan	FFA	15	15
Survey of local BME population	FFA	6	2
BME Health Needs Assessment	FFA	2	1
BME Health Research strategy	FFA	2	1
BME Service access audit/review	FFA	4	2
Policy on meeting dietary needs	FFA	7	0
Patient satisfaction survey on hospital meals	BP	5	0/na
Policy on provision of spiritual care	FFA	12	4
Policy on the provision of interpreting and translation services	FFA	13	2
Policy on the provision of information for patients in languages other than English	FFA	11	3
Annual figures of requests for information in different languages over last 3 years	BP	8	1
Policy on quality assurance for interpreting and translating services	BP	5	0
Annual figures of requests for interpreters by individual language over last 3 years	BP	10	1
Directory of key local BME agencies and individuals	FFA	8	2
Policy on harassment and bullying in the workforce	FFA	15	7
List of policies and functions	RRAA	12	6
Audit of employees by ethnicity over last 3 years	RRAA	11	4
Impact Assessments	RRAA	12	4
Rapid Impact Assessments	RRAA	13	7
Annual figures on workforce monitoring over last 3 years	RRAA	12	5
Policy on workforce development (equalities and diversity training)	RRA	8	2
Summaries of consultations, monitoring and assessments	RRAA	6	2
Policy on procurement of goods and services	RRAA	10	2
Annual progress report over last 3 years	RRAA/ BP	9	4
BME communities consultation strategy	BP	3	0
Annual report on complaints by ethnic group over last 3 years	BP	2	0
Annual figures on racial harassment/ discrimination (patients) by ethnic group over last 3 years	BP	2	0
Specific strategies on addressing BME health needs	BP	4	0
Evidence of planning/service delivery at local health partnership level	BP	5	0

Key Drivers: Fair for All – FFA, Race Relations (Amendment) Act (2000), Best Practice - BP
 2 Boards who did not return questionnaires did provide a collection of their policies and documents not included in above. A small number of Boards provided or had on their websites additional documents.

10.2 Fair Enough? Recommendations

Recommendation 1: The inclusion of a chart showing organisational responsibilities and/or a table showing the allocation of responsibilities would help in showing to outside readers which parts of the organisation would be responsible for taking work forward.

Recommendation 2: Both CRE and NRCEMH should publish information about forthcoming guidance and expected timescales for the coming year to assist public authorities in their planning.

Recommendation 3: Boards should increase their capacity by giving more attention to developing partnerships and external sources of assistance including the CRE, NRCEMH, Race Equality Councils, relevant Social Inclusion Partnerships and other local race equality providers

Recommendation 4: ALL functions and policies must be identified and listed, assessed and prioritised with information about how new functions and policies would be assessed. This process must be a priority for those several Boards and Trusts which have yet to start or complete the work that is required under the RRAA. Where possible functions and policies should be specific enough to allow meaningful analysis (e.g. either 'surgery' or 'primary care' would be too broad and would need to be broken down into its constituent parts).

Recommendation 5: Services are distinct from policies and functions. Action priorities for years 1, 2 and 3 should be based on relevance of functions to the General Duty and in the RRAA and should show how services link to functions.

Recommendation 6: Commitment needs to be demonstrated in measurable action points. It also needs to be matched by reflecting and meeting legal and policy requirements.

Recommendation 7: All Action Plans should indicate annual costings, specifying recurrent and non-recurrent expenditure. Annual reports should give some information about budgeted costs and actual expenditure.

Recommendation 8: It would be reasonable to expect a full action plan by 30 November 2003 to bring the new Quality Improvement Scotland and NHS Health Scotland into line with other Boards which will have to produce year 2 Action Plans at that time.

Recommendation 9: Boards and Trusts should consider how community planning and joint futures work might contribute to integrated working on areas which overlap boundaries and functions and contribute towards accessing services e.g. transport, residential care, information services

Recommendation 10: Schemes and Action Plans should clearly cover all the equality groups specified by Boards and Trusts AND meet the legal requirements of RRAA and policy requirements of FFA.

Recommendation 11: The statement of organisational intent must be explicit and include the range of aspects shown in the FFA HDL, including tackling racist behaviour.

Recommendation 12: All Boards and Trusts should consider the appointment or nomination of a co-ordinator for race equality issues. Where a race equality adviser or co-ordinator is in place, Schemes should also demonstrate both action aimed at mainstreaming and allocation of senior responsibility for the issue. This will demonstrate that planning and execution are being shared across the organisation – and avoid marginalisation of the officer and the issue.

Recommendation 13: Greater clarity on responsibilities will be achieved by specifying the lead officer and leads for different action points. Final accountability rests with the most senior officer and with Boards -reporting arrangements should be set out to demonstrate how this will be achieved

Recommendation 14: Procurement issues should be addressed urgently. Boards which have yet to deal properly with procurement issues can now benefit from the national guidance published by the CRE in July 2003 (issued in draft format in spring 2003).

Recommendation 15: Schemes should provide adequate information on plans to gather local population information including but not restricted to the 2001 census data. They should also consider how to make such information more widely available to others (e.g. voluntary sector and interested individuals) and how to further disaggregate information for wider equality issues (e.g. disability and gender).

Recommendation 16: NRCEMH should be involved in co-ordinating discussions on identifying local research needs and plans for conducting this through networks already established.

Recommendation 17: Any member of the public should be able to get a copy of any Race Equality Scheme and all public authorities should revisit this question in future in relation to publication of the Scheme and associated documents. This is an area where NRCEMH should act as a clearing house e.g. by facilitating web-links to Race Equality Schemes or by offering all Health Boards and Trusts the facility to put their Scheme and FFA Action Plan on the NRCEMH web-site which could act as a portal.

Recommendation 18: A glossary of terms and illustrations should be included in Schemes to make them truly accessible to all readers. The appendix to this report includes a starter glossary which may be of assistance.

Recommendation 19: All Action Plans should have milestones, targets and timescales. Many Action Plans should be more explicit about both outputs and outcomes.

Recommendation 20: Boards and Trusts should ensure the inclusion of black/minority ethnic people in general consultations as well as using specific mechanisms or consulting on issues deemed to be of particular relevance.

Recommendation 21: A consultative forum should be seen as only one mechanism for consulting black/minority ethnic people as well as potentially including representatives of other equality groups. Where a consultative forum is not to be set up, the Action Plan should indicate how the spirit of the FFA HDL will be met.

Recommendation 22: Early attention should be paid to the development of a range of mechanisms to ensure wider engagement with black/minority ethnic communities..

Recommendation 23: Staff should be recognised as key stakeholders in the successful implementation of the RRAA and FFA. Means should be found to involve staff and other workers in 2-way discussions.

Recommendation 24: NRCEMH should facilitate partnership working at local, regional and national levels for the core elements of a directory of individuals and organisations.

Recommendation 26: A strategy for communication should be set out by Boards and Trusts taking into account the information needs of different communities and how they will be met.

Recommendation 27: There needs to be a fuller recognition of the literacy and language profiles of local communities with some attention to the specific needs of asylum seekers and refugees. Steps should be taken to meet all needs identified.

Recommendation 28: Specify mechanisms for dissemination to and access by diverse communities to ensure that information will be freely accessible.

Recommendation 29: The CRE and NRCEMH should produce guidance on publishing to ensure compliance with the RRAA whilst also ensuring they address issues of multiple discrimination.

Recommendation 30: Boards and Trusts need to specify in more detail the practical steps they are taking to ensure services become truly accessible e.g. by signposting for users and referrals, training staff, and monitoring service uptake.

Recommendation 31: For national Boards, the services may be of less relevance. However, they should still consider if staff and visitors may have requirements in these areas.

Recommendation 32: The CRE and NRCEMH together with the Scottish Executive should consider national guidance which may be of assistance in service access issues.

Recommendation 33: Boards and Trusts should take steps to address personal care provision.

Recommendation 34: Boards and Trusts should take steps to address assessing and meeting dietary needs including consideration of visits to other organisations with a reputation for providing high quality, culturally sensitive catering.

Recommendation 35: Boards and Trusts should consider the development of a clear policy on interpreting for members of black/minority ethnic communities. There should be a strong linkage to the strategy for communications.

Recommendation 36: Schemes should be clear about the requirements of different staff thereby differentiating training contents according to their needs.

Recommendation 37: Consideration should also be given to how staff will be updated as their work changes or policies and services are developed or assessed for race impact as well as for possible future changes in legislation on issues such as discrimination in employment on grounds of religion.

Recommendation 38: Training is an area which requires some national consideration across sectors as quality and capacity for provision are relevant if public authorities are taking the RRAA requirements seriously. The CRE, NRCEMH and Scottish Executive should consider this issue together, involving other relevant partners.

Recommendation 39: NRCEMH should assist Boards and Trusts by facilitating information exchange about models of training which are currently happening and by providing guidance on what is required to meet RRAA and FFA. It is important that this is addressed with some speed as Boards and Trusts will be unable to deliver much of their planned programmes without ensuring their staffs are enabled to acquire relevant skills.

Recommendation 40: Schemes and Action Plans should consider evaluation of their training programmes, especially in terms of the effectiveness in terms of meeting RRAA and FFA and overall impact, including change in corporate culture that may eventually result.

Recommendation 41: Boards and Trusts should address developing, disseminating and implementing an equal opportunities policy.

Recommendation 42: Organisations should consider the distinction between dissemination and implementation, and note that case law around discrimination is beginning to demonstrate that employers need to show more than existence and communication of policies.

Recommendation 43: Where policies are in existence, Boards and Trusts should indicate what steps will be taken to harmonise them across different parts of the organisation and how staff will be updated as changes are made. For example, harassment is now to be included within forthcoming equalities legislation.

Recommendation 44: Boards and Trusts should set out in full the arrangements to meet the specific duties on employment i.e. staff in post, applicants for employment and staff leaving employment, applicants for training, and promotion, staff receiving training, results of performance assessment procedures, grievance procedures, and disciplinary procedures.

Recommendation 45: Action plans should give a target date for publication of monitoring information.

Recommendation 46: If monitoring is stated to be in place, there should be information from that monitoring in the Scheme with comments about any trends and action resulting from analysis of such monitoring.

Recommendation 47: Boards and Trusts should be more explicit on reporting of monitoring information, i.e., to whom, how, and how often.

Recommendation 48: Boards and Trusts should consider what opportunities there are to introduce positive action.

Recommendation 49: There should be arrangements to ensure minority ethnic staff can participate more fully in mainstream exercises using processes which bypass hierarchical lines such as suggestions schemes and representative or weighted staff surveys.

Recommendation 50: Boards and Trusts need to be more explicit about their arrangements for making race impact assessments with consideration of how to decide if a policy or function should be assessed, and whether it requires partial or full assessment. It is suggested that all new policies and functions are prioritised for evaluation to mainstream race equality as policies and functions are introduced.

Recommendation 51: The CRE, NRCEMH and Scottish Executive together should give consideration to providing detailed guidance on the development of race impact assessment tools, perhaps with appropriate templates which can be adapted for local use. It is also an appropriate area for work to be carried out on a national basis for similar themes.

Recommendation 52: All involved in race impact assessment would benefit by drawing from useful models and practice elsewhere in Europe e.g. Holland, Ireland (North and South). This work demonstrates the detailed attention which may need to be paid to this area.

Recommendation 53: Review the publication processes for each of the specified areas - assessments, monitoring, consultations, race impact assessments, schemes and action plans and consider how readers can give feedback on these.

Recommendation 54: Be more specific on the issue of publishing monitoring results and provide details on formats (including accessible formats such as different languages, large-print, Braille, audio or audio/visual formats, downloadable documents on websites, summaries, oral presentations etc. specifying which will be part of usual publication and which will be only on request).

Recommendation 55: Some explicit discussion about benefits across stakeholder would demonstrate how changes may benefit wider groups and contribute to the General Duty requirements of promoting equality and good relations between persons of different racial groups.

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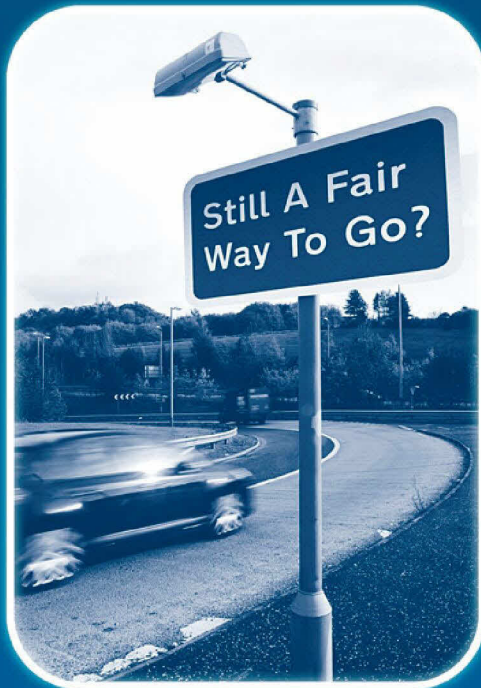
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