NHS

Greater Glasgow NHS Board

Greater Glasgow

Board Meeting
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IMPROVING CORPORATE POLICY TO ADDRESS INEQUALITY ISSUES

Recommendations:

The NHS Board is asked to:

1.   Endorse the conclusions of the Short Life Working Group.
2.   Charge the Chief Executive to establish a process to implement the recommendations.
3.   Receive an update within 6 months on the extent to which recommendations have been integrated into new organisational arrangements.

1.   ESTABLISHMENT OF SHORT LIFE WORKING GROUP

1.1   In March 2004, a report was presented to the NHS Greater Glasgow Board reviewing progress on the implementation of the previously adopted Glasgow Women's Health Policy. As well as describing activity associated with the Women's Health Policy, the report critically assessed its rate of progress and highlighted a number of organisational limitations in the current approach to implementation. The report provoked concern at the Board and following discussion, it was agreed to establish a Short Life Working Group to examine critically current issues relating to corporate policy development and implementation.

1.2   The group has been chaired by Rani Dhir, non-executive Board member with Councillor Danny Collins, also non-executive Board member, as the vice chair. Other members include a range of representatives from Divisions, Directorates and key partnerships. The full membership of the group is attached as Appendix 1.

1.3   The aim of the group was to make a series of recommendations as to how the health service in Glasgow could become more efficient and effective in defining policy aimed at addressing different aspects of inequality and health and also in the implementation of such policy. The group has met 6 times with a remit to consider the following:

- current barriers to the development of a corporate approach to policy making;
- the benefits of improving on the current situation;
- the means for more effective implementation of existing policy;
- scope of new policy development;
- the means for bringing forward evidence to support the planning functions of NHS GG as well as practice development in relation to equalities policy - structures and individuals;
- the means of rolling out policy implementation across the new structures and functions of NHS Greater Glasgow;
- individual and organisational accountability mechanisms.

1.4   A process was agreed by the group that comprised three phases of work. Firstly, evidence was collected on current perceptions, attitudes and activity aimed at addressing inequalities within NHS Greater Glasgow, current national policy developments and good practice within other related organisations. Secondly, this evidence was then used as the basis of a problem-solving phase in order to bring forward recommendations. Thirdly, the group considered how the new emerging organisational structure might impact on the Board's ability to address inequalities. The Community Health Partnerships, to be created as public health organisations, were seen as potentially powerful factors in changing health services to tackle inequalities and also to act as major local players in working across partnerships to achieve change. Ensuring the CHPs have the expertise, support and accountability for this activity was identified as important. Towards the end of the group's work the role of GGNHSB headquarters and the commitment to design the whole NHS organisation with a greater focus on wider health issues was also considered.

2.   UNDERSTANDING INEQUALITIES AND HEALTH

2.1   The Short Life Working Group identified that inequalities and health had a number of dimensions that needed to be articulated. Firstly, it agreed that identifying the role of the NHS in tackling inequalities required an understanding of poor health outcomes arising from high levels of poverty and social exclusion.

2.2   Secondly, it was agreed that it is also critical to focus not just on health outcomes but to recognise the significance of other pathways into poor health. The population is not homogenous and different groups are conferred different levels of status by society. As such individuals and groups can experience inequality and discrimination and an associated lack of power. Six strands of diversity have been recognised by policy makers; gender, sexual orientation, race, age, disability and faith. The experiences of being in one or more of these groups can act as a pathway into poor health and affect the nature of the response to health problems. Examples of this include the experience of racism or homophobia which affect self esteem and psychological well-being and which may then be translated into a range of poor physical and mental health outcomes. Racism and homophobia amongst health care providers may then impact on the quality of care that is provided and limit the extent to which specific needs are met. In terms of the relationship between gender and health, the paper presented to the Board on the Women's Health Policy highlighted that there is a growing international consensus that a focus on gender and health is the best way forward to address the health needs of women and men and that a population approach which is gender blind does both sexes a disservice.

2.3   Importantly, a lack of awareness regarding issues of discrimination as well as the needs of a diverse population could also serve to reduce the effectiveness of health interventions and potentially run the risk of reinforcing existing inequalities. The role that identity plays in health and the inequalities that flow from that are therefore as important to understand as differences in health outcomes between poor and affluent population groups and that both forms of inequality affect each other.

2.4   It was noted that the health service has traditionally been charged by Government with the responsibility of addressing health inequalities and therefore that it is important for this complexity to be unravelled in order to ensure the most effective and efficient response. Although addressing inequality and health and promoting equality cannot be the sole responsibility of the health service, the role of the Short Life Working Group was to improve clarity as to how the NHS in Glasgow can maximise its contribution.   The following were identified as the key areas for health service intervention:

- working in partnership with others to address determinants of health where they are health limiting and build social change;
- ensuring that internal policies are designed to impact on health determinants in relation to, for example, employment opportunities to reflect diversity in the population,
- identifying NHS action which can play a part in reviving local economies and improving social regeneration;

- working in conjunction with others to promote the health of those who bear the greatest burden of poor health;
- developing capacity for change within communities who bear the largest burden of poor health
- developing the practice of all health care practitioners such that they are better equipped to understand the pathways into poor health and can incorporate this understanding into the management of health problems;
- ensuring equitable provision of services to meet differences in need;
- redesigning services to ensure that they are accessible to all and that they reflect an understanding of the needs of a diverse population;
- ensuring compliance with all legislative requirements to maximise equality and prevent discrimination.

2.5   In light of this, the group reiterated the findings in the original paper presented to the Board in March which highlighted the barriers and ongoing challenges to further progress with the women's health policy and the implementation of other policies. These focused on two main issues. Firstly, the health service is fundamentally a clinically focussed and led organisation. It does respond effectively to some policies that affect staff, (e.g. PIN guidelines and health and safety policy) and in Scotland, as in Glasgow, has begun to address the implications of the Race Relations Amendment Act. Largely however, it does not develop, interpret or implement policy with implications for service delivery and practice aimed at tackling inequalities. The result is that there are few accountability mechanisms to ensure implementation of any policies that do exist or mechanisms for transferring examples of good practice into mainstream activity.

2.6   The effect of an uneven approach to tackling inequalities can lead to a blame culture rather than create the opportunities for change to governance and accountability frameworks that would create new cultural norms. It also undermines the credibility of NHS Greater Glasgow in its efforts to facilitate activity within its partner organisations aimed at tackling inequalities.

2.7   Secondly, the paradigm of illness management within the health service i.e. the biomedical model, has created a culture whereby the origins of poor health problems are rarely assessed or managed. This can lead often to inappropriate or even health limiting forms of care such as prescribing tranquillisers for social problems or not recognizing the risks faced by women experiencing domestic violence. Where there are activities aimed at addressing health inequalities there is a greater emphasis on changing health behaviours amongst individuals rather than on identifying and resourcing necessary institutional change.

3.   THE PROCESS OF WORK OF THE SHORT LIFE WORKING GROUP

3.1   The first phase of the work of the Short Life Working Group involved the establishment of a baseline of information from which the current situation could be assessed, good practice elsewhere considered and strengths and weakness within NHS Greater Glasgow be determined. The focus of this evidence collection was four-fold:

- national policy and planning with respect to addressing and mainstreaming equalities;
- consideration of organisational developments within the statutory and voluntary sectors which have been effective in relation to corporate policy and mainstreaming the tackling inequalities;
- getting a better understanding of NHS Greater Glasgow by surveying activities and perceptions on inequalities and diversity within Divisions, actions and perceptions of Directorates, perceptions and practice of clinicians, the learning from the Sandyford Initiative and the social model of health care, and the learning accrued from developing the Race Equality Scheme;
- observations from representatives of partner structures.

3.2   The second phase of the work of the Short Life Working Group involved consideration of the considerable volume of complex findings. In a problem solving exercise the group was asked to consider the following:

- agreeing what the findings tell us;
- agreeing whether a corporate approach to inequalities is good business and the benefits;
- reviewing current strengths in the system;
- what else needs to be put in place;
- how this could be achieved.

3.3   In order to facilitate this work, the group was asked to consider the questions above in relation to a case study on domestic abuse which is available as Appendix 2. Another case study is also presented based on recent published research highlighting the impact of inequality and discrimination on health and its implications for the health service.

4.   FINDINGS

4.1   The process undertaken by the group to look outside the organisation, within the organisation and to request feedback from partners on their perceptions of the effectiveness of the work to tackle inequalities produced a plethora of information and data. Reports and presentations were prepared for the group on other organisational activity and the surveys of perceptions and activity within NHS Greater Glasgow and these are available. The notes of the group's problem solving exercise are attached as Appendix 3. Key findings from the totality of the group's work are summarised as follows:

- there is a growing national expectation that the health service will make improvements with regard to mainstreaming equalities. As part of UK government developments in establishing a Commission for Equality and Human Rights, the public duty for race will be extended to gender and disability will follow soon. Within Scotland, an Equalities Forum has been established to provide strategic leadership to the health service;
- additionally, a number of important national and local developments have great significance in terms of addressing inequalities and health. These include the development of Community Health Partnerships and the implementation of Community Planning. The knowledge and skills framework for Agenda for Change also requires an understanding of equality issues;
- organisations which also have a fundamental responsibility to address inequality issues (the approach of Oxfam as an equally large organisation was assessed) have reorganised themselves to ensure that responsibility for the issue permeates every aspect of the organisation and as a result have improved their efficiency and effectiveness in delivering their organisational aims. This comprehensive approach was further endorsed by a report from East Renfrewshire Council which showed that an explicit corporate policy structure and function has aided them in the delivery of objectives with implications for the whole Council;
- within NHS Greater Glasgow, there are demonstration initiatives such as the Sandyford which highlight the potential and benefits of shifting the current paradigm when responding to health problems which arise from social problems, inequality and discrimination. The learning from these initiatives needs to be utilised more effectively in planning for change;
- there are also a range of dedicated posts with responsibility for addressing various aspects of inequality and supporting institutional exchange (e.g. the Women's Health Team, the Priority Needs Team, women's health race equality advisors in some divisions) but the activities of these post holders are not being coordinated within a common framework;
- development of the Race Equality Scheme within NHS Greater Glasgow has yielded positive developments in terms of coordinating structures and some accountability mechanisms. There are also improvements in factors that contribute to make services more accessible such as the availability of interpreters and translated information. There is limited

      information as whether this has affected attitudes to race issues or knowledge of factors that affect the development of poor health;

- despite the existence of good practice, survey evidence highlighted that there is currently an unacceptable level of variation and inconsistency in the system in tackling inequalities for an organisation with responsibility for delivering policy. This variation covers attitudes, understanding, knowledge of policies, nature and range of activity, structures designed to ensure a systematic approach and commitment. It cuts across both Divisions and Directorates;

- a high level of support exists across managers and clinicians for improving the current situation and for formalising the issue of inequalities as a core aim of NHS Greater Glasgow.

5.   CONCLUSIONS

5.1   Overall, the group endorsed the view that there is both a desire and a need to address the issue of inequalities in its complexity in a more systematic and accountable fashion in order to build a modern, contemporary service in Glasgow. This should have the effect of improving services for patients and health as well as maximising clinical effectiveness and partnership working. Achieving such a change requires as a first step a more explicit statement on the role of NHS Greater Glasgow and its workforce, an agreement that there are implications for all services, settings and the entire workforce and meaningful action. Taking a mainstream approach requires the integration of the different aspects of the inequalities agenda into policy, programmes and practice. Such an approach recognises the need to provide targeted services for specific population groups where required but more fundamentally establishes the principle and the means to ensure that a sensitivity to inequalities and the needs of a diverse population becomes the responsibility, in different ways, of everyone.

5.2   The group was mindful of the fact that there are currently a lot of specialist structures, specialist staff and good practice within the system and that any changes need to consolidate and build on this. These include:

- partnership working and multi-agency planning aimed at improving determinants and coordinated response to issues relating to regeneration;
- structures for ensuring implementation of Fair for All across NHS Greater Glasgow and named staff with key responsibilities;
- corporate diversity objectives within some Divisions for named staff;
- corporate planning structure for the implementation of the Glasgow Women's Health Policy;
- women's health, men's health and priority needs specialists within Health Promotion, Public Health and some Divisions;
- health topic specialists with equality mainstreaming expertise e.g. in sexual health;
- health improvement initiatives aimed at addressing poor health with certain population groups;
- demonstration activity at service delivery level e.g. Sandyford Initiative;
- demonstration practice development e.g. link midwives for domestic violence.

5.3   Despite this and taking into account the scope of health service organisations in responding effectively to inequality issues, the group was concerned that existing activity was marginal and not sufficiently coordinated. It recognised that considerable energies are being exerted but they are not necessarily all pulling in the same direction and that there are policy and practice gaps. More specifically, there is a significant organisational development challenge to ensure leadership at the highest level, achievable aims, effective governance and a corporate training and communications strategy.

6.   RECOMMENDATIONS

6.1   On the basis of the findings of the research phase and the problem solving process, the short life working group makes the following strategic recommendations:

- corporate policy on inequalities and health is embedded into all the work of within NHS Greater Glasgow with a coherent system for implementation such that it impacts on health improvement and service and practice development;

- corporate policy on inequalities and health is embedded into all the work of NHS Greater Glasgow in its partnership arrangements with other organisations especially in relation to Community Planning;

- greater recognition is given to existing demonstration initiatives such as the Sandyford Initiative and their role in providing the basis for the planning and service design of other parts of the health service in Glasgow;

- functional arrangements be put in place to ensure that a mainstreaming approach is recognized within individual and collective objectives and job descriptions for new appointments;

- financial planning is realigned and audited to ensure all resources take the need to address inequality issues into account;

- added value is created by bringing together existing activity focused on addressing inequality issues relating to gender, race and disability into a single system-wide support mechanism to support policy development and facilitate implementation and mainstreaming throughout the organisation;

- frameworks of corporate, clinical and performance governance are designed to ensure that inequalities are addressed;

- methodologies are designed to improve dialogue with patients and communities (both geographic and interest);

- NHS Greater Glasgow is organised to ensure that legislative requirements to maximise equality and prevent discrimination are implemented to the fullest extent;

- improvements are made to current data collection to enable monitoring and audit of change;

- a research and evaluation agenda is established in conjunction with the Glasgow Centre for Population Health and relevant University departments.

6.2   The new organisational arrangements designed to ensure delivery on Partnership for Care and Community Planning need to take these strategic recommendations into account. The group therefore further recommends that a detailed programme of action is agreed as soon as possible to deliver change.

APPENDIX 1: SHORT LIFE WORKING GROUP PARTICIPANTS

CHAIRPERSON: Rani Dhir, Non-executive Board member
VICE CHAIRPERSON: Cllr. Danny Collins, Non-executive Board member

Catriona Renfrew: Director for Planning & Community Care, GGNHSB
Evelyn Borland: Acting Director of Health Promotion, GGNHSB
John Crawford   PHPO Geographical Ethnic Minorities, Health Promotion Department, GGNHSB
Sue Laughlin: Women's Health Co-ordinator, GGNHSB
Nicky Coia: Senior Health Promotion Officer, GGNHSB
David Walker: Assistant Director of Planning, GGNHSB
Iain Wallace: Medical Director, Primary Care Division
Andy Carter   Head of Personnel, Primary Care Division
Alison Bigrigg: Director, Sandyford Initiative
Rosie Ilett   Associate Director Health & Inequalities, Sandyford Initiative
Maureen Henderson: Director of Nursing, South Glasgow Division
Flora Muir   Quality Co-ordinator, Glasgow South Division
Irene Barr   Deputy Director of Nursing, South Division
Linda Fleming: Director of Corporate Planning, Yorkhill Division
Helen Ostrycharz   Human Resources Director, Yorkhill Division
Eleanor Stenhouse   General Manager, Maternity & Neonatal, Queen Mother's Hospital
Liz Love   Divisional Nurse, North Glasgow Division
Liz Curran: Strategy Manager for Gendered-based Violence, Homelessness Partnership
Duncan Booker   Co-ordinator, Glasgow Healthy City Partnership
Charlie McMillan: PSPI Implementation Manager, Involving People Team, Scottish Executive Health Department

APPENDIX 2: CASE STUDIES

CASE STUDY 1: DOMESTIC ABUSE

As part of its policy framework on domestic abuse, the Scottish Executive has issued guidelines for health care workers to respond to the issue. The policy recognises domestic abuse as a major public health and human rights concern as well as a serious social problem.

The guidelines target the role of the health service, recognising that health care staff are often the first point of contact for women who have experienced domestic abuse. They locate the role of health within a wider multi-agency response to the issue and explicitly specify expectations and responsibilities of health care staff.

The following case study provides an example of two potential responses to domestic abuse, one which is informed by the SE's health guidance on domestic abuse and one which does not take this into account.

- A woman who has experienced domestic abuse presents at a health service (A&E, GP etc). She has physical injuries and states that she had an accident at home.

Response 1 – informed by Guidance on Domestic Abuse:

- Staff take account of the wider circumstances of the woman's life and are aware that injuries could be result of violence. Raise this sensitively/in confidence with woman and record info. Advise women of potential options, provide info on health and other partner services, refer to partner agency if appropriate.

Benefits:
- These actions could increase effectiveness of health response e.g. may contribute to a reduction in the level/frequency of abuse in future, lead to fewer repeat presentations to GPs and other health services and to better physical and mental health for the woman over time.
- Other benefits include reducing the time spent in the health system, overall health improvement for patient and more cost effective to the NHS.

If the woman was black or experiencing poverty for example, then these additional social factors would also have to be taken into consideration.

Response 2 – does not take account of the Guidance:

- Staff don't take account of the wider social circumstances, take explanation at face value, don't ask questions, treat injuries and discharge woman.

Consequences:
- Woman goes back into situation, at risk of further violence.
- Over time, domestic abuse continues, likely to be repeat presentations at A&E, GP for related symptoms such as depression anxiety, addiction, chronic physical conditions etc.
- Woman stays in health system long term, physical and mental health of patient deteriorates over time with attendant financial cost to the NHS.

This case study illustrates the benefits of a policy led approach, which is explicitly linked to the role of practitioners within the NHS e.g. by recognising the impact of wider social issues and structural inequalities on health, staff can provide more effective interventions.

CASE STUDY 2: EATING DISORDERS AND SELF HARM

A study reported in the British Journal of Psychiatry this month found that high levels of discrimination against gay, lesbian and bi-sexual respondents including physical attacks and bullying highlighted an increased risk of mental health problems.

In this case study a young man presents to the General Practitioner with his mother on account of his rapid weight loss.

<u>Response 1</u> – informed by a recognition of sexuality issues amongst young people and the possible relationship between homophobia and poor health.

- The GP tries to investigate if the young man is troubled by his sexuality. Young man reveals that he has come out to his friends and that he is being systematically bullied. Young man also discloses cutting behaviour successfully hidden from parents. Encourages young man to contact relevant support group and provides information as to contact details and to keep in touch .

Benefits:
- These actions could increase effectiveness of health response e.g. may contribute to a reduction in self harm and disordered eating, lead to fewer repeat presentations to GPs and other health services and to better physical and mental health for the young man over time.
- Other benefits include reducing the time spent in the health system, overall health improvement for patient and more cost effective to the NHS.

<u>Response 2</u> – GP refers young man for medical investigations for weight loss which eventually find nothing remiss.

Consequences:
- Eating disorder becomes more established.
- Presentation to A and E for self harm and suicide attempt.
- Young man becomes chronic user of health system with repeat referrals to specialist mental health care with attendant financial cost to the NHS.

APPENDIX 3: NOTES FROM DISCUSSION GROUPS

WHAT FINDINGS TELL US?

- There is desire to address equality more systematically.
- Make more explicit what we do – and need to do – on inequalities.
- Guidance, corporate support, consistency.
- Capture, consolidate and transfer learning.
- "De-chore" this agenda!
- Pro-actively respond to legislation (but not only be led by law!).
- Ethical/Statutory/Service quality arguments need to be used to make a business case.

WHY A CORPORATE APPROACH?

- Delivering a quality service has to incorporate a recognition of a response to equality/ inequalities.
- Ensuring a diverse workforce that can progress and reflect population.
- Building a modern, contemporary service (business case).
- Maximising both clinical effectiveness and partnership working.
- Enhancing sustainability.

CURRENT STRENGTHS?

- Corporate diversity objectives (particularly race) translated to performance management systems in divisions
- Some incorporation of equality issues in induction (but variable)
- Very positive grassroots work, including partnership working (e.g. BEM, voluntary sector projects).
- And much of which pre-dates legislation, so some historical base on some issues.
- National resources on diversity and equality which also support local agenda.
- Information systems have developed, but gaps existing champions and resources in Greater Glasgow (this group itself!).
- Relatively individual projects that may go system-wide.

HOW WE COULD IMPROVE?

- Harness positive developments, energies in same direction: consolidate and enhance existing work thru corporate group?
- A recognised resource for CEO/Chair (and not located only in HR).
- "As basic as washing your hands" – but balance between voluntarism and enforcing.
- Clarity about responsibilities of NHS plus profile of equality issues (awareness in order to ask the right questions - not just openness to diverse patient groups).
- Identifying key steps: induction and CPD, Glasgow-wide policy, service improvements.
- Formal mechanisms (e.g. proofing each report as well as "symbolic gestures").
- KSF approach.

WHAT ELSE IS NEEDED?

- More awareness needed (but issue of time and resources).
- Need for action plan and starting point.
- Pulling together existing work/good practice: audit of experience?
- Danger of box-ticking.
- Corporate, strategic message and associated structure (unit? [which SEHD is establishing] – needs to be resource/facilitating support on which services can draw, but doesn't "let them off the hook").
- Functional leads, rather than issues-based?

- Translating policy into practice (and feedback loops).
- O.D. issue for governance arrangements, particularly in this context: led at highest level, but goes throughout the system (higher profile).
- Lines from senior management to front line?
- Improve community engagement/partnership working as supports – needs formalising.
- Organisational systems, rather than relying on particular individuals.
- Potential for using existing staff from divisions, not just seeking central resources.

  *A headquarters function
  *Responsible for drawing together existing and future work
  *Some specialist, but linked to change and potential for dynamic partnership with divisions/ across boundaries
  (a unit or a description of a set of necessary activities/relationships)

- CHPs.
- Public sector diversity unit (including Local Authority), given shared and cross-cutting agenda (but governance issues).