Greater Glasgow & Clyde NHS Board

Board Meeting

Tuesday 18th April 2006 **Board Paper No. 06/16**

Head of Inequalities & Health Improvement

Reporting on Equality Legislation

Recommendation:

Members are asked to:

1. Approve the attached report on race equality action 2002-2005.
2. Endorse the NHSGG&C Race Equality Scheme for 2005-2008 with the understanding that work is required to encompass the Clyde element of the new expanded organisation.
3. Note the role of the newly established Corporate Inequalities Team in supporting NHSGG&C in complying with current and future equality legislation.

1 Introduction

The Race Relations (Amendment) Act 2000 (RRAA) requires all public bodies to have undertaken an analysis of their functions and to have published a Race Equality Scheme, setting out what actions will be taken to ensure the organisation prevents racial discrimination and promotes racial equality. NHSGG's first Race Equality Schemes and associated action plans were published in November 2002 and March 2003 respectively. There is a legal requirement to publish a report based on progress on the 2002-2005 Race Equality Schemes. This report fulfills that purpose.

During 2006, equalities legislation will be brought into law covering disability and gender. It is anticipated that legislation on age and sexual orientation will come into force in future years. Work in NHSGG&C is commencing to understand the similarities and differences across the legislative strands.

2 Coordinating race equality work– the approach taken in NHS Greater Glasgow

The approach taken by NHSGG has been designed to ensure that there is sufficient local

ownership and commitment to race equality. Each division within NHSGG therefore carried out an analysis of their functions and compiled a race equality action plan specific to their own circumstances.

It was however recognised that there were a number of strategic issues that could best be tackled on a pan Greater Glasgow level. Work on these was co-ordinated through the establishment of a Race Equality Co-ordinating Committee, comprised of senior officers from each division within NHS Greater Glasgow, and was chaired by the Acting Director of Health Promotion.

The key strategic issues have been identified as

- Interpreting
- Advocacy
- Training
- Employment
- Research
- Information
- Communication
- Involving people/listening to communities
- Catering
- Complaints
- Procurement

The attached report on Race Equality Action (Appendix 1) focuses on progress in relation to these key strategic issues. Reports on actions specific to each individual part of NHSGG are available, and can be accessed on the Board's website.

Appendix II is the Race Equality Scheme 2005-2008 which sets out future actions for the organisation based on the further development of, and consultion on, the Report of Race Equality Action.

Due to the degree of organisational change in NHSGG&C, work will continue to refine the 2005-2008 Race Equality Scheme.

3 Accountability to BME communities

In the course of finalising these reports the following consultations were undertaken:

- A meeting with BME communities facilitated by the West of Scotland Race Equality Council plus follow-up distribution of information as requested.
- Letters to the database of 166 BME organizations directing them to the Boards website, and asking for comment.

4 Public Sector Duty

The Race Relations (Amendment) Act introduced the concept of a positive duty to work to achieve race equality in public bodies. More recently amendments to the Disability Discrimination Act bring a new public sector duty on disability in December 2006 and (following the successful passage of the Equality Bill) a gender equality duty will be introduced at the same time.

By 2006 therefore there will be a Race Equality Duty, a Disability Duty and a Gender Equality Duty that all place legal obligations on the public sector and require the production of race, gender and disability equality schemes – either separately or in harmonized format.

NHSGG&C have established a corporate Inequalities Team whose responsibilities include supporting the organization in complying with the legislative duties and in developing a systematic and co-ordinated approach to reducing inequalities in health.

5 Conclusion

This report is based on a substantial amount of work undertaken within NHSGG, and its review of race equality action 2002/2005.

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NHS GREATER GLASGOW

REPORT ON RACE EQUALITY ACTION 2002/2005

NOVEMBER 2005

Report on Race Equality Action – NHS Greater Glasgow (2002/05)

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APPENDICES

These appendices are reports on progress on race equality action from the constituent divisions of NHS Greater Glasgow.

Appendix I – NHS Greater Glasgow Board

Appendix II – NHS Greater Glasgow – North Glasgow University Hospitals Division

Appendix III – NHS Greater Glasgow – Primary Care Division

Appendix IV – NHS Greater Glasgow – South Glasgow University Hospitals Division

Appendix V – NHS Greater Glasgow – Yorkhill Division

Report on Race Equality Action – NHS Greater Glasgow (2002/05)

1. Introduction & Context

1.1 The Race Relations (Amendment) Act 2000 (RRAA) required NHS Greater Glasgow to identify and assess its functions for impact on race equality in relation to services and employment and report annually on progress in mainstreaming race equality.

1.2 In 2002, the Scottish Executive Health Department provided policy guidance through HDL 'Fair for All: toward culturally competence services' (FFA), and established the National Resource Centre for Ethnic Minority Health (NRCEMH) to support NHS organisations throughout Scotland in the development of this work. Subsequently the Commission for Racial Equality (CRE) and NRCEMH developed a joint implementation & monitoring framework to assist NHS organisations in the delivery of legislation and policy guidance

1.3 The current approach builds on the work on race equality undertaken in NHS Greater Glasgow prior to the RRAA and FFA. In 1996, Greater Glasgow Health Board endorsed a Race Equality in Health and Healthcare Policy, and established an Ethnic Minority Health Advisory Committee (EMHAC). The unified NHSGG Board subsequently endorsed a revised Race Equality Policy in September 2002 following an extensive review and consultation exercise.

1.4 Processes and structures for co-ordinating NHSGG race equality work and involving minority ethnic communities are currently evolving in light of the NHS White Paper 'Partnership for Care' and the Patient Focus Public Involvement initiative.

1.5 The report highlights the approaches being taken; the progress underway utilising identified pan NHSGG strategic themes; and key issues for future development in mainstreaming race equality. Appendices I-V outline progress against the Board/division specific race equality action plans. (It should be noted that workforce/employment issues are reported separately and in detail in the annual PIN policy monitoring report).

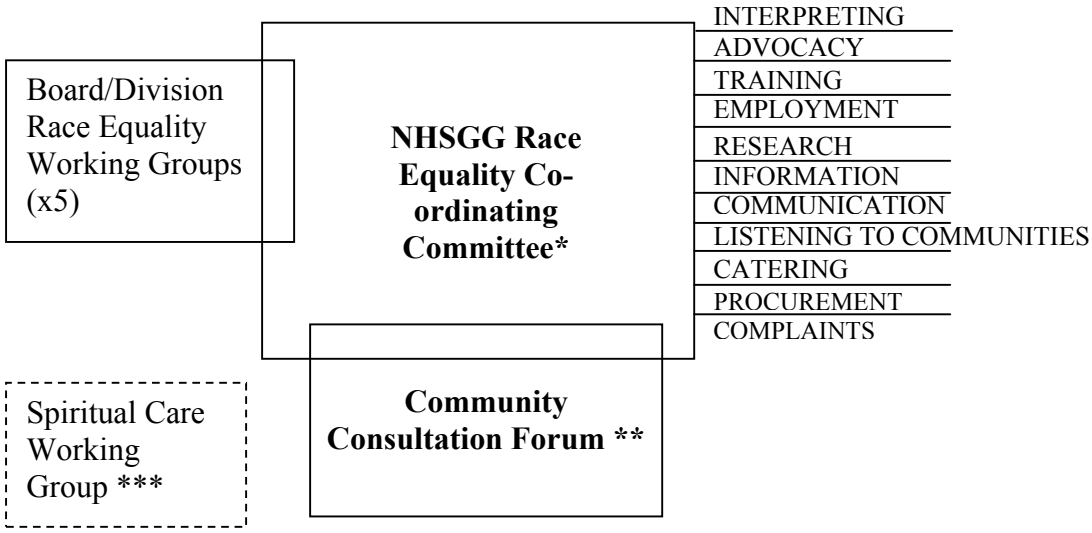
2. The Developing NHSGG Approach

2.1 In 2002 NHSGG decided that each of the five local NHS organisations should develop and submit its own Race Equality Scheme and action plan. This decision was based on the independent legal status of each organisation (at that time) and the desire to ensure local ownership of and commitment to the race equality agenda. In April 2004, following legislative change NHSGG became a single, unified and accountable organisation, however for the purposes of retaining local ownership and commitment each of the operational divisions continued to develop and report on race equality initiatives specific to their part of the organisation.

2.2 While encouraging local action, there was also recognition of the need for a coordinated approach to be taken on a pan NHSGG basis across the following strategic cross-cutting themes – Interpreting; Advocacy; Training; Employment; Research; Information; Communication; Listening to Communities and Catering. Lead officers were identified to co-ordinate the development of this approach. During 2004/05 an additional two themes were identified for further development - Procurement and Complaints.

2.3 The Race Equality Coordinating Committee, chaired by the acting Director of Health Promotion as the designated director in terms of FFA, comprises senior managers from each organisation within NHSGG and was supported by a number of pan GGNHS working groups, each taking forward work on one of the strategic themes. In addition each part of the organisation (division/Board) had its own mechanism to co-ordinate race equality action in respect of their individual Race Equality Action Plan. It was envisaged that a BME community consultation forum, would evolve, which would along with other relevant organisations be represented on the Race Equality Coordinating Committee. Progress on this has been slower than anticipated due to the work in ensuring community engagement for example in Community Health Partnerships, Community Planning and through NHSGG's Involving People events.

2.4 The diagram below illustrates how it was anticipated these structures would fit together.



* The Race Equality Co-ordinating Committee was functioning with representatives solely from NHSGG organisations. It was intended to widen the membership to include the Local Health Council, the Area Partnership Forum, the West of Scotland Race Equality Council, and representatives from minority ethnic communities (through the mechanism of the Community Consultation Forum).

** A process of revising the existing minority ethnic advisory committees in light of previous experience, and views expressed during the public consultation on the Race Equality Policy and in the Listening to Communities events is 'on hold' at the present time. NHSGG is mindful of the current extent of public engagement activity and the capacity of BME communities to respond. It is anticipated that consideration will be given to co-ordinating engagement activity to allow maximum influence of BME

communities on policy and service developments, along with other diverse communities. (It should be noted that a major health & well being survey for BME communities has been undertaken along with a number of BME specific health needs assessments).

*** The development of the NHSGG Spiritual Care forms a separate but related strand of work. Following SEHD guidance a Spiritual Care working group was established to develop the Spiritual Care policy. This policy was endorsed by NHSGG Board in January 2004 and established a Spiritual Care Committee as part of NHSGG's governance arrangements.

3. Report on Progress

Progress on each organisation's race equality action plan is reported in Appendices I-V. Progress on the strategic cross cutting themes is as follows:

3.1 Interpreting

NHSGG was an active partner along with Glasgow City Council (GCC), Strathclyde Police, Scottish Refugee Council, and Glasgow Asylum Seekers Support Team in overseeing the development of the Interpreting Partnership and the work of the service provider, Glasgow Translation and Interpreting Service (GTIS). This service was directly managed through GCC's Social Work Services.

Accurate interpreting is a key to ensuring quality of clinical decision-making and health care and has become of increasing significance due to the asylum seekers dispersal programme in Glasgow, and the number of refugees choosing to reside in the area.

Prior to the dispersal programme GTIS was undertaking between 50-60 assignments per week, whereas the average weekly number is currently around 1100. On average 76% of interpreting assignments are within NHSGG direct services.

In 04/05, NHSGG contributed £775k to the Interpreting Partnership. This was match funded with monies available through the National Asylum Support Service contract with GCC. As the number of asylum seekers in Glasgow continues to grow, along with the number of refugees who choose to remain in Glasgow, it was anticipated that the costs of interpreting provision would also rise initially. Evidence suggests that the number of interpreting appointments for the indigenous BME population also rose.

NHSGG made a submission to the Scottish Executive for additional funding to meet the additional health related costs in meeting the needs of asylum seekers, including the interpreting costs.

Internally NHSGG has an established Quality Standards in Interpreting Working Group which developed and now monitors the Policy on Interpreting and Access Protocols for staff, as well as assisting in monitoring the quality of the interpreting services provided by GTIS. In October 2005 the Quality Standards Interpreting Working Group, along with GTIS, undertook a review of the quality standards of GTIS. A report on this will be fed into the Interpreting Partnership for consideration.

In May 2004, GTIS received the award for Best Team at the Annual COSLA Award Ceremony.

Future Challenges

- Continue to monitor progress and improve the quality of interpreting support.
- Publicise the availability of interpreting support to BME communities.
- Expand the availability of telephone interpreting support – initially for emergency situations in accident and emergency, and maternity sites throughout NHSGG.

3.2 Advocacy

NHSGG and Glasgow City Council Social Work Services jointly commission the Ethnic Minority Advocacy Service (EMAS) to provide advocacy support into BME communities including asylum seekers. The service level agreement (£100k in total) commenced in January 2003 funds 5 staff to provide and co-ordinate an independent professional advocacy service to local minority ethnic communities. In addition EMAS also attracts funding as part of an access to work programme to train and employ approximately another 20 advocates. During 2004, 219 people received advocacy support of which 60 were asylum seekers and 47 of refugee status. The range of issues covered included health, housing, welfare benefits, immigration and education. EMAS links into other advocacy providers where appropriate. An annual review of this contract was undertaken on a joint basis. In 2006 an independent evaluation of EMAS will be commissioned.

Future Challenges

- Recommissioning of BME advocacy services in light of independent evaluation (2006).

3.3 Training

This is a summary of how NHS Greater Glasgow (NHSGG) has responded to training its staff in meeting the general duty of the Race Relations (Amendment) Act (2000).

- All NHS Divisions have now included Race Equality as part of their corporate induction process.
- In response to various training needs analysis, several different training programmes have been developed since November 2002 across NHSGG. This has included training which:
    - Addresses and tackles health inequalities within minority ethnic groups;
    - Identifies potential discriminatory practices within the organisation;
    - Supports and complements other legislative requirements e.g. impact assessments, ethnic monitoring of patients;
    - Promotes religious and cultural diversity and appropriate treatment of patients from black and minority ethnic backgrounds.

- There is evidence of monitoring of racial group (and wider diversity monitoring) to training opportunities although this needs to be extended to smaller scale training and e-learning environments;
- There is evidence that Core Dimension 6 of the Knowledge and Skills Framework is being used to map existing training programmes in order to ensure that all staff have appropriate levels of understanding of equality and diversity issues;
- A Glasgow wide diversity training group has been established since July 2005 to review and consolidate equality and diversity training across former NHS Divisions. This group consists of lead representatives for training and other staff within each former NHS Division. The aim of this group is to harmonise training opportunities across the Board area on race as well as wider equality and diversity issues.

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At a national level the NRCEMH along with National Education Scotland are negotiating the development of work to establish an equality and diversity module for undergraduate courses with direct employment with health and social services.

Future Challenges

- Co-ordinate equality and diversity programmes including training resources/curriculum material across NHSGG.
- Market and communicate information on training programmes across the NHSGG workforce through ongoing programmes of awareness and continues to monitor the number of staff trained.
- Evaluate the effectiveness of training on local practice.
- Develop training programmes that support health inequalities and improvement functions; impact assessment training for managers.

3.4 **Employment**

Revision of Equal Opportunity Policy

A revised PIN guideline on Diversity was produced in early 2005. It was anticipated that NHSGG will revise its own equal opportunity policy following the issue of this guidance.

NHS Staff Survey

A key challenge of the NHS is to establish a staff governance standard to ensure all staff are supported by the organisation in relation to personal and professional development. In 2003 all NHS Scotland organisations participated in a workforce survey to assess and benchmark performance in relation to staff governance.

The recent NHS staff survey provides us with some baseline information on the organisations ability to prevent racial discrimination within the NHS and also mechanisms in dealing with harassment and bullying. Quantitative information on the number and scope of cases involving racial harassment are also available.

Ethnic Monitoring

In April 2004, the Information and Statistics Division published Monitoring of Ethnicity in Health guidance which gave specific information on implementation of new ethnic codes to record ethnicity. Clearly this represents a new challenge to NHS Divisions both in terms of recording ethnicity in employment and service delivery and NHS Divisions are currently at different stages in terms of monitoring ethnicity of applicants.

Over the past year, there have been various levels of activity by each NHS Division in implementing and promoting good race relations within the organisation and this is documented below.

Organisation	
Greater Glasgow NHS Board	• Ethnic monitoring of all grievance/harassment/ disciplinary/applications for employment/applications for graining/applications for promotion/appraisal outcomes/reasons for leaving/benefits within the organisation. • Organisation has ethnic breakdown of current staff. • Dignity at work guidelines adopted and implemented.
Primary Care Division	• Ethnic monitoring of all grievance/harassment/ disciplinary cases within organisation underway. • Organisation has demographic breakdown in excess of 90% of the workforce; remaining component exercised their right not to disclose such personal sensitive data. • Staff Survey has been completed assessing view of staff including discrimination in the workplace. • Race Equality Steering Group & Disability Steering Group membership includes representation from Trades Unionists on the Employee Relations Council. • New Application Form (on line) and Equal Opportunities Form devised to respond to sexual orientation, religious belief statutory guidance and in anticipation of anti-discriminatory legislation on age.
North Glasgow Division	• An Equal Opportunities Policy has been reviewed and implemented. This was distributed to all staff with HR policy folders and is covered at induction and staff training. • A data capture exercise was undertaken in Jan/Feb 04 to capture ethnicity data from existing staff. There was a very disappointing response to the exercise (approximately 10%) and attempts have been made via HR Managers/Lind Managers and training sessions to encourage staff to provide this data. The data is captured for new starts through the recruitment process.

	• Data received has been input to the payroll record and used as required for national returns. The data is, however of limited use for monitoring given the small percentage of the overall workforce for whom the data is available. It is hoped that this will alter once staffing questionnaires to capture a variety of data including ethnicity are issued nationally later this year in connection with the SWISS project. • HR Managers receive regular information from recruitment on the ethnicity of applicants applying for posts from initial application to successful candidate. This data is then used locally for monitoring purposes. • In connection with the 2004/05 SAAT return data has been requested from Service HR Managers to break down numbers of discipline, grievance, training and bullying and harassment issues by ethnic origin to enable monitoring in these areas. • The organisation continues to participate with the GOPIP project in conjunction with Caledonian University.
South Glasgow Division	• Monitoring form developed and in place in the Training & Development Department for internal courses. Further work to develop division wide monitoring. • At Divisional level work is in hand to adapt current recruitment advertisement reporting and software to include Ethnic and Equal Opportunities Data. • Draft census form has been finalised and will be active in May 2005. Will be inputted to local and Swiss Database. • System being developed to report staff standard data for disciplinary and grievance by Ethnic Group.
Yorkhill Division	• Ethnic Monitoring of all grievance/harassment/ disciplinary cases within organisation underway • Staff Survey has been completed assessing view of staff including discrimination in the workplace • Part of the Human Resources quarterly report to the Division's Management Group contains information on the number of individuals recruited from an ethnic background

Recruitment and Retention

Over the previous 12 months, there has been considerable development in areas of recruitment across NHSGG including:

- Access to the NHS - A 24 week programme targeting people from black and minority ethnic backgrounds combining an academic programme run by the University of Strathclyde with a sixteen week work placement opportunity in the NHS.

- Building a Bridge Project- a course designed in partnership with Reid Kerr College, Glasgow Healthy City Partnership, Scottish Enterprise Glasgow, Health Scotland and the Ethnic Minority Enterprise Centre which aimed to increase involvement from black and minority ethnic communities in health promotion related activities. The majority of the course is VQ accredited. European funding has been granted to develop this programme (til December 2007). The Building A Bridge project was linked with the Care Careers programme (see below)

  Following research into BME community organisations and how they contribute/what prevents them from contributing to the health agenda, a capacity building programme will be developed.

- Care Careers - Working for Health in Greater Glasgow (WHIGG). This programme attempts to address specific labour market shortages in NHS particularly in areas relating to basic level entry into the NHS. As part of this programme a specific joint funded post (2 years) has been created with Glasgow Anti-Racist Alliance to mainstream the practice and processes of recruiting young BME people.

- Communication- radio broadcasting on Awaz FM has highlighted employment opportunities in the NHS.

- Recruitment Activities - the recruitment team recently advertised in the Scottish Asian Sports Association (SASA) brochure as part of the UK Asian football championships. This yearly event attracts more that 10,000 local people from black and minority ethnic communities across Scotland.

Future Challenges

- Work toward a single system for capturing employee details including monitoring across equality spectrum. (ongoing)
- Analyse and utilise the workforce information in workforce planning. (ongoing)

3.5 **Research**

In order to develop a strategy for NHS Greater Glasgow and partners to initiate and support research activities on black and minority ethnic communities, the Black and Minority Ethnic Research Group has been formed. Because NHS Greater Glasgow was playing "catch up" regarding evidence-based planning relating to minority ethnic health, an assessment of research was carried out in order to prioritise local research in Greater Glasgow.

First, an audit of current and recent research was conducted to determine gaps in knowledge. Several priorities for future research were identified, including but not limited to studies on mental health, studies on health-related lifestyles as well as the social and individual circumstances that affect health, and studies of disease prevalence. Significant progress has been made in Greater Glasgow to address the identified priorities. One study specifically commissioned by the Health Board that addresses each

of the three priorities mentioned above was the Health and Well-being Study of Pakistani, Indian, African and Caribbean communities, was completed in March 2005 and which complements a recent study conducted by the Chinese Healthy Living Centre. Both studies were based on a questionnaire designed to assess the Health and Well-Being of the overall population of Greater Glasgow, thus comparisons between groups will be possible. The BME Health and Well Being studies along with comparative data will be launched in February 2006.

3.6 **Information**

In our first two annual reports we highlighted the gaps in our information on the health status of Black and Minority Ethnic groups (BME) and the challenges faced in progressing work to address these. We also commented that it would be a long process. Looking back, our experience over the last three years has underlined these facts. Nevertheless we have made good progress in several key areas, and the work of the last three years has been invaluable in establishing what we know (and more importantly what we don't know) about BME communities, helping us understand the process of ethnic monitoring and developing strategies to begin to build up our evidence base on BME health.

LOOKING BACK

1. Census Profiles

One of the key sources of information on BME communities is the 2001 Census. The Census recorded data on the demographic characteristics of the BME population, evidence of which until now has been largely anecdotal and patchy. One of our main tasks, outlined in the Race Equality Action Plan (REAP), was to produce local profiles from these data. In order to do this we undertook a series of detailed analyses of data drawn from the Census. This work has highlighted many important facts about BME communities in Greater Glasgow.

These profiles have been brought together in a report intended to highlight some of the key differences found between ethnic groups. The report includes sections on the geographic distribution of BME communities across Greater Glasgow, age distributions, family structures (marital status, family size, lone parent families), self reported health ('health not good' and long term limiting illness), housing type and tenure patterns, economic activity rates and occupation type, educational qualification and current religion. The report draws comparisons with all Scotland figures where appropriate.

In summary we found that Greater Glasgow has the largest BME population in Scotland (4.5% of the total population or 39,318 people). 38.7% of the total Scottish BME population live in the Greater Glasgow area, and 45.7% of all BME people in Greater Glasgow are Pakistani. In one area of Glasgow people from BME communities make up nearly 40% of the total population. The BME population is younger than the White population (29.5% under 16 compared to just under 19% for the White groups), is more likely to be married than those from the White groups (53% vs. 38%), and have larger families (29% had 3 or more dependent children compared to 14% of White people). BME people also have a more positive view of their general health than the White population (91% vs. 86%). We know from other sources that Greater Glasgow residents

are more likely to live in a flat than people from other parts of Scotland. However, the Census analysis provides further evidence that a higher proportion of BME people in Greater Glasgow live in a flat than those from the White groups (56% vs. 49%), and that BME households are more likely to be overcrowded than White ones (32% vs. 18%). Analyses also show that people from BME communities are less likely to be economically active than those from the White groups. However, those that are economically active are more likely to describe themselves as managers and senior officials and be self-employed. We have also found evidence of substantial differences in educational attainment e.g. 50% of Africans possess a degree or equivalent whereas 44% of Pakistanis have no qualifications.

This work has been presented to the NHS Boards Race Equality Coordinating Committee (RECC), BME Research Strategy Group, and shared with other NHS Boards through the National Resource Centre for Ethnic Minority Health Information Network (NRCEMH IN) where it has generated a great deal of interest and discussion. It is now ready for wider dissemination throughout the NHS Board.

2. Developing the Evidence Base

Two other key tasks were identified in our REAP. The first was to develop an evidence base on BME health, and the second to work with NRCEMH Information Network to secure a consistent national approach to ethnic monitoring. These two tasks were very closely linked and we have had varying degrees of success with each.

(i) Stock-take: Identifying the Gaps

We collect a great deal of data in the health service on an individual's journey through life (birth, child health, morbidity and mortality) but historically we have been inconsistent in our approach to recording ethnicity. There is for example just over one quarter of a million admissions to general and acute NHSGG hospitals each year and admission datasets could provide an important source of BME health and health service use information. There is a field on these datasets to record a patient's ethnicity, however there is no mandatory requirement to fill it in.

In order to get a better understanding of the gaps in our information we needed to take stock of the current state of ethnicity recording from routinely collected sources such as SMR01 (General/Acute hospitals), SMR11 (Neonatal hospitals) and Child Health Surveillance Pre-school (CHS-PS) datasets, and identify any local sources of ethnicity information that may be available. A group of information specialists and records officers from the various NHSGG divisions was brought together to discuss these data sources, start to pool ideas as to how any changes could be best implemented across NHSGG, and share good practice from any other work. Generally speaking the picture is very poor. On the acute hospital admission dataset there is only 22.5% completion of the ethnicity field for 2004 and of that 22.5% less than 2% were from a BME group, and this varied greatly by hospital. In 2002/03 the completion rate was just over 10% so there is some evidence of improvement in recording but clearly a great deal still needs to be done. Recording of ethnicity on the current neonatal dataset is

better at approximately 50% but again this varies greatly by hospital. There was no routine collection of robust ethnicity data on most datasets. On the more positive side the CHS-PS system does record robust ethnicity data and provides information on immunisation uptake, breast-feeding and low birth weight babies.

The group also identified a more fundamental problem with these datasets. Many use different ethnicity classifications, and none use those from the 2001 Census. Moreover the datasets only contain a field for ethnicity and none of the associated variables such as religion, language and preferred gender of health care provider that are needed in order to ensure we provide a more culturally competent service.

Some progress was made with the NHSGG group. However, it quickly became clear that its membership and remit needed to be re-thought. We are now re-evaluating the role and function of this group especially in light of the changes being suggested to the remit of the NRCEMH IN.

ISD will be making changes to the SMR datasets to allow use of the 2001 Census classifications later this year and one of our challenges over the next months and years will be to develop strategies to ensure we put in place the necessary requirements to fully utilise these developments (e.g. training, Information and IT). This is especially important with the developing ISD Equality and Diversity Information Programme (EDIP).

(ii) **Working with NRCEMH Information Network (IN)**

Tied closely to local developments in this area is our commitment to working with NRCEMH IN to secure a consistent national approach to ethnic monitoring. The NHS Board is fully committed to the work of the NRCEMH IN and is an active member on the group. We have collaborated in the development of a 5-year business plan, which sets out the work that needs to be undertaken on a national basis to progress the task of ethnic monitoring. We have also shared our census profiles and examples of good practice with other NHS Boards. NHSGG officers were also part of the sub-group formed by NRCEMH IN to develop an Ethnic Monitoring Toolkit, which has recently been made available to all NHS Boards in Scotland.

The remit of the NRCEMH IN is being revised at the moment. A lot of valuable work has been done through this network but in order to move forward it is going to evolve into an implementation rather than information network, which NHSGG will continue to actively support.

3. <u>What Could Have Done Better?</u>

The Census profiles, the stocktaking exercise and work with NRCEMH IN have all been essential pre-requisites for developing a strategy for the next three years. A useful part of the process is an assessment of what areas we have failed to make progress in and what we have learned from this.

Based on our initial timescales we should have progressed further towards establishing a robust evidence base on BME health but it is probably fair to comment that some of our initial targets were a little optimistic. Establishing a baseline is difficult when there is no information available and no tools in place to kick start the process. The stocktaking exercise underlines this. However, we know from discussions at the NRCEMH IN that this is not purely an NHSGG problem.

The Ethnic Monitoring Toolkit and Communication Guidelines released in the summer were specifically designed to start to address the information gap in the short term while in the longer term the NRCEMH IN business plan is developed. So far we have failed to capitalise on this. This has been partly due to a failure in communications within the NHS Board, partly to technical difficulties, and partly due to the fact that we relied a little too much on it just being 'out there'. However, the opportunity has not been completely missed, as the toolkit has only been available for a relatively short time. We will address this.

We could also have made better use of our information group. As already discussed we fulfilled the original purpose of the group but failed to subsequently come up with a suitable remit for it's future direction. We now have a clearer idea of the purpose and direction of such a group and the final section of this report begins to describe what we see as its core functions.

LOOKING FORWARD

Much of the work of the last three years has involved looking at the process of ethnic monitoring. Looking forward we will need to focus more on what structures we need to put in place in order to develop our evidence base and start to monitor and evaluate outcomes.

Clearly as the EDIP develops and starts to roll out we will need to be ready to respond. Key to this would be the establishment of an IT and Information Strategy group. We will need to carefully consider the membership of this group but envisage it will include a mix of IT systems specialists, information analysts, records managers and research and evaluation officers. This would allow us to look at the operational aspects of data collection and management, and our information requirements (e.g. making changes to existing IT systems, training records officers and front line staff in data collection, and analysing and disseminating information throughout the organisation). At least one member of this group would link into the new NRCEMH implementation network that will be formed later this year.

We also need to consider how we will effectively utilise the Ethnic Monitoring Toolkit. Recent experience has shown us that no matter how good the tool is we cannot simply release it without putting in place the necessary backup in terms of communications and training. This could be developed through a collaboration between the new IT and Information group, the NHSGG RECC and NRCEMH networks.

A great deal of the work we have to progress over the next three years will involve the development and implementation of new procedures and the establishment of new policies for data collection. We will therefore need to consider at an early stage how we intend to assess the impact these developments have on ethnic groups and identify a

suitable tool to do this. This will be part of the remit of the IT and Information group and again discussions with the RECC and NRCEMH will be a vital part of this process.

The Future

- Establish structures and procedures to implement ethnic monitoring across NHSGG.

3.7 **Communication**

NHSGG has developed a Communication Strategy and initial work has been undertaken on considering future engagement through BME media. In addition translation of Corporate Board information was offered.

Following an extensive audit of health information available in languages other than English a report and directory 'Black and Ethnic Minority Health Information Resources' was launched in May 2004. This was followed up in the autumn of 2004 by a seminar on social marketing to BME communities. In addition a hyperlink was created between Scotlands Health on the Web site and NSW Multicultural Health site from which health information in up to 26 languages can be downloaded.

Currently, an audit within NHSGG of services and topic information available in other languages is underway. Following a pilot in Yorkhill the audit will be rolled-out throughout NHSGG. It is anticipated this work will be completed by the autumn of 2006.

The Public Education Resource Library (PERL) in conjunction with Glasgow City Council has developed public information booths with touchscreen computers. These booths are situated in public spaces and buildings and information is available in a 'talking heads' format in languages other than English. Guidelines on the production of translated materials have been developed as part of work on alcohol and drugs. These guidelines will form part of the support package for staff following the audit of topic and service information

Further information on communication with communities can be found in section 3.8 'Listening to Communities'.

The Future

- Further evolve the draft Communication Strategy to target BME communities, including exploring social marketing approaches.
- Development of support materials for staff considering translating information.

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3.8 **Listening to Communities**

The 'open space' work undertaken by NHSGG in 02/03 highlighted the health priorities of BME communities, and ways in which the communities wished to be involved in ongoing service planning and community development around health. The priorities for

the communities helped shape the Race Equality Action plans and, in particular, the identified cross-cutting themes.

The evolution of the Ethnic Minority Health Advisory Committee into a wider Community Consultation Forum has been much slower than anticipated and this is currently not in place. The evolution of this work will be considered alongside the developments in Community Health Partnerships and in Community Planning, around community engagement. There were, however, a number of related initiatives that have significantly contributed to engaging with BME communities.

1. The development of a robust BME research strategy (see section 3.5), and identified BME communities. The research reports will feed into the emerging NRCEMH research network, and planning processes within the restructured organisation.
2. Specific service related work on gynaecology, drugs and alcohol and womens health which have been pivotal in identifying issues relating to the delivery of services to BME communities. For example, an extensive audit process within addiction services has been undertaken and built into a comprehensive action plan to ensure services and information meet the needs of BME communities.
3. NHSGG has secured BME communities views and participation into the work around the Involving People Network. Progress on this has been slow during the period of reorganisation.
4. The capacity building course 'Building a Bridge' skills BME individuals to not only take information into the communities, but also in listening to the communities needs and bringing this information back into the planning processes. The course is being further developed to support the "health capacity" of community based BME organisations following research.
5. NHSGG has establish an Involving People Committee to oversee the governance of all polices and processes which involve engaging with communities.

The Future

- The Involving People Committee will review policies and practice associated with Patient Focussed Public Involvement and consider the best ways to involve BME communities (2006).

3.9 **Catering**

The provision of Halal, Kosher and Vegetarian meals to ethnic minority patients became a cross cutting theme through all the Race Equality Schemes developed in NHSGG for November 2002. The South Glasgow University Hospitals NHS Trust being the largest user of Halal and Kosher meals in Scotland was therefore asked to lead on this work. The priorities would be to initially address Halal and Kosher meals due to the demographics of the population, and problems being encountered in these areas.

Halal

The work commenced in January 2003 with a meeting with Catering Department, Scottish Healthcare Supplies, West of Scotland Race Equality Council and Dr Nazir Chaudry as a representative from Glasgow Primary Care Trust Community Forum. This meeting was to discuss more fully the needs of Muslim patients, current provision and develop a plan for the way forward.

The actions undertaken as a result of that meeting included:

- A visit to a production unit run by Glasgow City Council for school meals etc.
- Interviewing 15 Muslim in-patients, using structured questions, to gauge their viewpoint on the ethnic minority meals provision.
- Issues highlighted by the patients were incorporated into a revised menu. The revised menu was piloted by patients in the Maternity Unit. This was using a different supplier.
- The Maternity patients were also interviewed, again using structured questions.

The positive results from the pilot led to agreeing menu items with Scottish Healthcare Supplies who then consulted every Catering Unit within Scotland and commenced work with the supplier for distribution etc. checking of premises to meet their legal obligations.

The completion of the work includes a translated laminated menu that can be used by all hospitals in Scotland. These are available via the meals distributor.

Kosher

In September 2003 two Patient Focus groups were held with Jewish patients. This provided valuable feedback to develop an action plan to address their food requirements on the meal provision and the cultural difficulties encountered by Jewish patients. The focus groups were recorded and analysed to produce a report of all issues to be considered. The report was agreed by the Jewish Representative Council before a group was formed to take this work forward.

Catering Managers throughout the city, and the Jewish Representative Council formed the group and have regularly met to discuss the report and the subsequent actions. The actions undertaken as a result of meetings include:

- Local enquiries with Jewish Care Scotland and East Renfrewshire Council and the associated problems in developing a partnership for supply of meals
- Present costs allocated to feed patients in comparison with the cost of purchasing Kosher meals (and Halal)
- Clarification, city wide, on usage of Kosher Meals for the last six months. This highlighted that the South Glasgow Division and Leverndale Hospital are the main users, i.e. 700 and 250 meals respectively being ordered per month. Other hospitals uptake of meals is so low that they requested meals from South Glasgow Division as required.
- Lack of the provision of suitable starters and desserts and sourcing these
- Tasting session to compare existing supplier and an alternative supplier with representatives from the Jewish Representative Council. Patients from the original focus groups participated in the tasting session.

Approval is currently being requested regarding the funding for the additional costs associated with providing on improved quality of meals and suitable starters and sweets. Once the funding is agreed then the group will finalise the menu choices and request that Scottish Healthcare Supplies enter contract arrangements with the new supplier.

Major Challenge

Each Catering Department is challenged by the high cost of meals purchased in comparison to the daily costs available per patient. For example, the daily allowance per patient may be in the region of £2.59 (varies from site to site). This does not meet the cost of one main course Kosher meal, which can be £4.50 and more depending on the meal type. Patients require two main courses per day.

Other work has included:

Catering for Functions

To be able to provide appropriate food for Muslim and Jewish people attending a function in the South Division a couple of external suppliers were explored/tested. This information has been shared with Catering Managers at the January 2005 meeting.

The Future

- Develop an action plan to audit the success of the new Halal menu.
- Resolve/conclude the provision of Kosher meals.
- Ensure issues concerning the provision of ethnic minority meals from impact assessments carried out throughout the new Acute Division are included in this action plan.
- Investigate with public partners diets for dysphagic patients (i.e. provision of pureed food).
- Individual focus groups will be held with the other communities, i.e. Sikh, Hindu and African Caribbean, to establish their needs. Once needs are known action plans will be developed to link each community's needs to menu arrangements.
- Ensure that mechanisms are in place to reassure minority ethnic communities that suitable meal provision is available.

3.10 **Complaints**

The Listening to Communities events identified complaints as an issue for BME communities who found the procedures complex and difficult to understand. A pragmatic decision was taken to await the revised complaints direction and guidance for NHS Scotland which arrived during 2004/05, and the issue was added as a cross cutting theme to NHSGG's race equality action plan.

The new guidelines took effect on 1st April 2005 and aim to simplify the complaints handling process, shifting the balance in favour of the patient. There are increased targets for response times and a renewed emphasis on access to advocacy and support and conciliation. NHSGG has revised its policy and procedures in light of the Scottish Executive guidance, and implementation will be supported by the provision of information and support through Citizens Advice Bureaux and improved patient information in other languages and formats. In addition the NHSGG policy and procedures have been race impact accessed and an action plan will be implemented during 2006.

The Future

- Implement monitoring arrangements and publish the results.
- Implement the marketing of the complaints procedure into BME communities.
- Provide communication support to the person making the complaints eg. ensuring the availability of advocacy services and access to interpreting support.
- Include complaints in staff race equality training.

3.11 **Procurement**

Procurement has latterly been added to the cross-cutting themes following the issue of guidance from the Commission for Race Equality. Whist currently NHSGG has a standard change in conditions of contract for services which requires suppliers to meet race relations legislation, it is recognised that this theme requires more detailed consideration and action utilising the guidance. It should be noted that much of the procurement function will be moving to a national basis. An action plan based on the guidance will be developed in 2006.

The Future

- Race impact assess the procurement function within NHSGG and develop and action plan.

4. Overall Challenges

Mainstreaming race equality within the context of the changing legislative and policy landscape offers substantial challenges for NHSGG, alongside the major re-organisation exercise that took place in 05/06.

A short life working group on inequalities identified deficiencies within NHSGG in its capacity to respond effectively and systematically to the health effects of inequality and the needs of diverse populations. Their report reflects the experience of implementing the Race Equality Scheme/Race Equality Action Plans in that whilst there has been significant progress in specific areas, efforts to mainstream race equality into policy, practice and performance management have been patchy.

Towards the end of 2005 NHSGG agreed to establish a Corporate Inequalities Team with a remit for developing policy; managing the legal requirements of public sector duties of current and impending equalities legislation; developing a planning and performance management framework; and supporting the development of new, effective methodologies for changing practice.

In taking this agenda forward, the main challenges to NHS Greater Glasgow and Clyde will be:

- Ensuring NHSGG&C complies with race relations legislation within the emerging equality and diversity agenda.
- Ensuring that the 'one system' model continues to maintain a focus on race equality through balancing overall accountability with local ownership for action.

- Harmonising approaches to policy, planning and performance management across Greater Glasgow and Clyde
- Demonstrating a 'step change' in NHSGG&C's race equality work through the work of the Corporate Inequalities Team.
- Further developing the capacity of black and minority ethnic communities to engage with and influence the planning and review of health related services either solely within NHSGG&C or in partnership with others.
- Joining up work with other partners for the provision of direct services to black and minority ethnic communities or for the purpose of learning across organisations.

NHS
Greater Glasgow and Clyde

RACE EQUALITY SCHEME

2005-2008

November 2005

CONTENTS

RACE EQUALITY SCHEME – NHS GREATER GLASGOW

NHS Greater Glasgow as a public health organisation responsible for strategic planning and policy, performance management and service delivery will actively pursue race equality through its role in;

- **Corporate planning and policy**
- **Capturing information on illness, health and well being of its resident population**
- **Planning and reviewing the delivery of services to meet identified health needs**
- **Working in partnership with statutory, voluntary, community and commercial organisations to improve the health of the local population**
- **Performance managing services commissioned either directly or jointly**
- **Employing staff**
- **Ensuring financial governance of public funds**

1. Introduction

1.1 This Race Equality Scheme (RES) describes how NHS Greater Glasgow (NHSGG) will meet the general and specific duties contained within the Race Relations (Amendment) Act 2000. The scheme covers the period 2005-2008 and will be monitored and reviewed on a regular basis to ensure NHSGG is working towards achieving racial equality. Increasingly this will be done collaboratively with the other inequality strands of gender, disability and poverty and in line with the anticipated new legislative requirements. The monitoring and review processes will involve staff, local people and other stakeholders, and as such the RES should be seen as a 'live' document sensitive to changes in national and local environments.

1.2 A detailed plan, based on the actions outlined in the report on race equality action (2002-2005) – see Appendix I, will be available in 2006/2007, with further detail being added following the current major reorganisation being undertaken within NHSGG.

1.3 On 1st April 2006, the boundaries of NHSGG will be expanded to include the areas covered by Renfrewshire and Inverclyde councils and additional parts of East Renfrewshire and West Dunbartonshire councils. The evolving Race Equality Scheme for NHS Greater Glasgow & Clyde will reflect these changes.

1.4 This report was written prior to the changes in NHS Greater Glasgow boundaries. Comments on the challenges in harmonising work within the expanded boundaries are included in the final section of the report.

2. Background

2.1 In 1996, Greater Glasgow Health Board endorsed a Race Equality in Health and Healthcare Policy which has subsequently been reviewed in light of the new legislation and policy directives. The Greater Glasgow NHS Board endorsed the revised Race Equality Policy in September 2002 following an extensive consultation exercise. This

policy reaffirmed the commitment of NHS Greater Glasgow's organisations to actively promoting racial equality and eliminating racial discrimination. The policy stated:

"The aim of the Race Equality Policy is to ensure that NHS Greater Glasgow as employers and service providers comply with legislation and policy guidance through delivering on the detail and spirit of the Race Relations Act 1976, the Human Rights Act 1998, Race Relations (Amendment) Act 2000, and the Scottish Executive Health Department 'Fair for All' guidance."

3. Key Principles

3.1 The key principles of NHSGG in implementing race equality practice are:

- Equality of access and service provision for all service users
- Respect for diversity within communities as well as across communities
- Accountability and transparency
- Partnership with users and communities
- Evidence based approaches to service provision
- Integral monitoring and evaluation
- The need for comprehensive organisational development.

4. Legislation

Three key areas of racial equality legislation impact on NHSGG:

4.1 **Race Relations Act 1976** – is the main source of anti-discrimination legislation which makes it unlawful to discriminate on the grounds of race in employment, training and related matters, education, and in the provision of goods, facilities and services.

4.2 **Race Relations (Amendment) Act 2000** – was introduced following the Stephen Lawrence inquiry and enhances the 1976 Race Relations Act through placing general and specific duties on public services. The general duties of the Amendment Act make provision to:

- Outlaw race discrimination in all public functions
- Place a general duty on public bodies to promote race equality in employment and service planning and delivery.
- Give powers to government to impose specific duties on public bodies to promote race equality.

The Commission for Racial Equality (CRE) was enabled to enforce these specific duties through statutory Codes of Practice which guide public sector agencies as to their responsibilities in promoting race equality. Overall, the emphasis of the Amendment Act is on mainstreaming race equality practice at all levels within public bodies.

4.3 **The European Convention Human Rights Act(1998) –** binds the parliament of the UK and Scotland and all public authorities to consider the human rights aspects of their work which under Article 14 explicitly prohibits discrimination on the grounds of race.

4.4 **Equality Legislation** - Strengthened legislation around disability and gender is due to be introduced in the near future. By the end of 2006 there will be equalities duties for race, disability and gender that place legal obligation on the public sector. In addition a single Commission for Equality and Human Rights will come into place in 2008. Work is already underway to prepare for a new Single Equality Act.

5. Policy

5.1 The Scottish Executive policy response to Parliament's change agenda includes a shift from the concept of the 'average citizen' to one that recognises the diversity of all citizens. These include:

5.2 **The Social Justice/Equality Agendas** – are to the forefront of the thinking and work of the Scottish Parliament. These seek to ensure the inclusion and engagement of those in Scottish society who hitherto have been disadvantaged in/excluded from decision making processes and mainstream service provision. In particular, the Scottish Executive's Equality Strategy will be supported by the CRE's Codes of Practice, and the Scottish Executive review on race equality. The Equality Strategy supports the vision of

"an open, just and inclusive Scotland where respect and understanding are fostered, and where everyone is encouraged and enabled to live, work and take part in society to their full potential, free from prejudice and discrimination".

5.3 **The Scottish Health Plan "Our National Health"** – encompasses ethnicity within its framework for tackling inequalities in health. NHS Boards are charged with the responsibility for planning and delivering services to meet the diverse needs of the communities they serve.

5.4 **Achieving Better Services for Patients** – directs Boards and Trusts in relation to their responsibilities for extending patient and public involvement in the NHS in order to provide patient focussed services. A patient focussed service requires:

- Good communication, including listening and talking to patients, the public and communities, as well as NHS staff;
- Knowing about those who use the service and understanding their needs;
- Keeping users of the service informed and involved;
- Having clear explicit standards of service;
- Maintaining politeness and mutual respect;
- Having the ability to respond flexibly to an individual's specific needs;
- Ensuring effective action is taken to improve services.

5.5 **Fair for All : Towards Culturally Competent Services** – a national stocktake exercise provided a baseline of strategic and operational performance in relation to ethnicity and health. This led to clear guidance to NHS Boards (HDL (2002)51) on mainstreaming cultural competency into the planning of services rather than continuing to focus on culturally-specific, short term projects.

5.6 **Partnership for Care** - directs NHS Boards in the reorganisation of health services into single accountable entities and in the involvement of communities in the planning and review of services.

6. Joining Up

6.1 The requirements of the Race Relations (Amendment)Act 2000 and Fair for All : Towards Culturally Competent Services are complementary and a joint monitoring and evaluation framework was developed to assist NHS organisations in planning and reporting on progress. This has been utilised within NHSGG. Progress to date is outlined in the Report on Race Equality Action 2002/05 details progress on the 2002/05 Race Equality Schemes and associated action plans.

Further development of an inequalities planning and performance management framework will be undertaken in 2006 to encompass disability, gender and socio-economic inequalities.

7. Accountability

7.1 NHSGG is committed to accountability and transparency and will demonstrate this through

- Submitting an annual report to the Commission for Race Equality detailing progress made against an inequalities action plan.
- Providing information to the National Research Centre for Ethnic Minority Health which assists the Scottish Executive Health Department in monitoring NHS Boards performance against the deliverables in the HDL on cultural competence as part of the NHS Scotland performance management framework.
- Being accountable to local BME communities through their involvement in the review and monitoring processes.
- Establishing internal governance and performance management arrangements for inequalities issues
- Reporting annually to GGNHS Board on progress against an endorsed inequalities action plan.

8. Process of Development

The following steps have been taken in the initial development and further evolution of the Race Equality Scheme (RES).

8.1 Preparation of the 2002-2005 RES, and associated action plan

- Consideration of relevant information from locally based work on race quality and BME health issues; work through external partnerships; and publications, reports and strategies both local and national.
- Endorsement by Greater Glasgow NHS Board of the revised Race Equality Policy in 2002 following extensive consultation with BME communities.
- A process of functional assessment by lead officers.
- Consultation with BME communities and NHSGG staff on the RES.
- Endorsement by Greater Glasgow NHS Board of the Race Equality Scheme 2002-2005.

8.2 Development of Race Equality Action Plan (2002/05)

- Listening to Communities - Engagement with BME communities to identify and priorities health related issues.
- Development of race equality action plans.

8.3 Review of the RES and associated action plans 2002-2005. (Appendix I)

- Review of progress against race equality action plans for the component divisions of NHSGG – Yorkhill, South Glasgow, North Glasgow, Primary Care and Board HQ.
- Review of progress on identified cross-cutting themes – Report on Race Equality Action 2002/2005
- Reporting to BME communities around progress on 'Listening to Communities' issues, and identification of strengths, weaknesses and gaps.

8.4 Development of the Race Equality Scheme 2005-2008.

8.5 Endorsement by GGNHS Board

- It is anticipated that the Race Equality Scheme 2005-2008 will be submitted to the GGNHS Board meeting in April 2006 for consideration and endorsement.

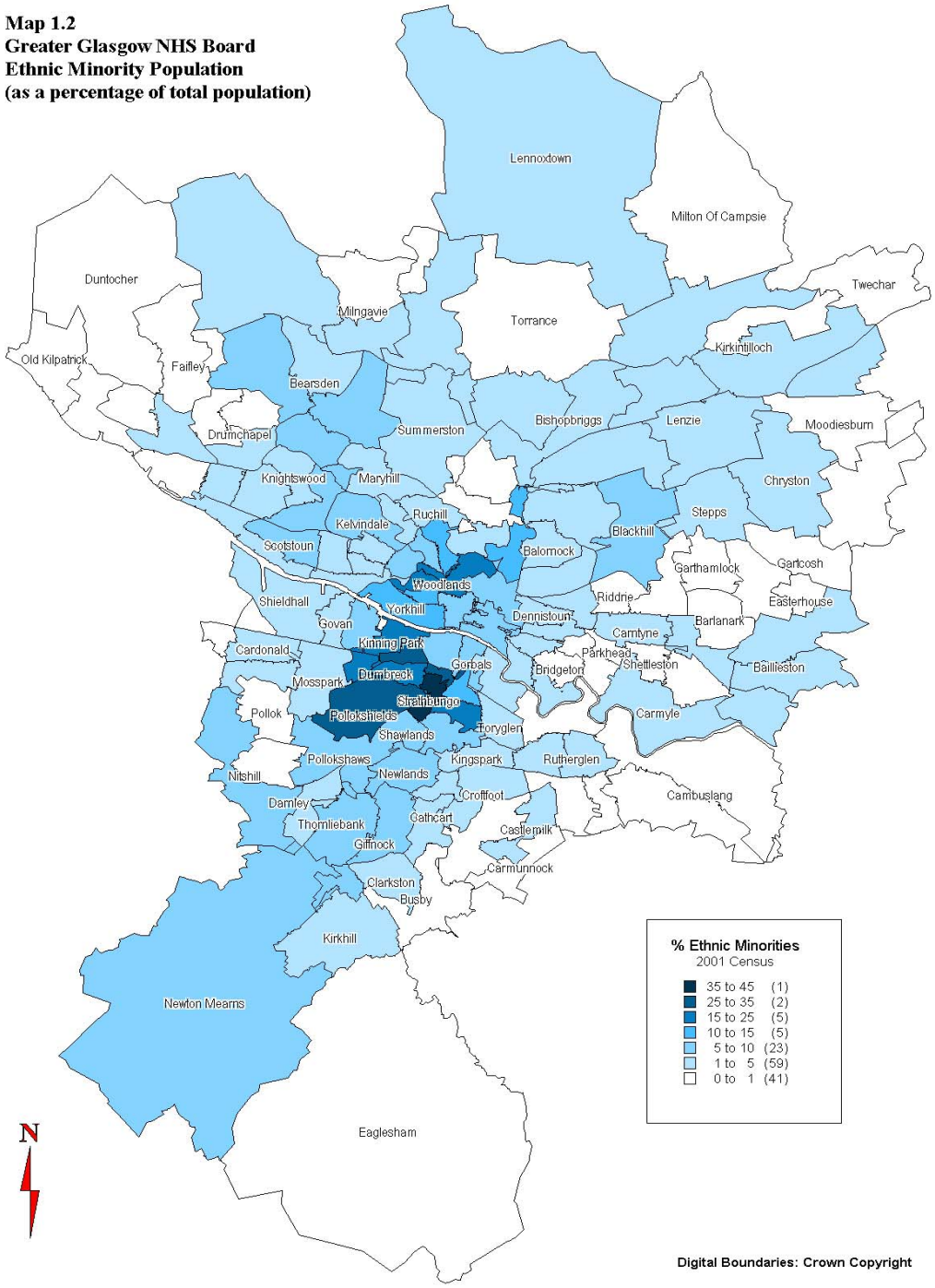
9. Demography

A detailed analysis of the 2001 census information has recently been completed. This indicated that 4.5% of the population in NHSGG come from BME communities. Table 1 below shows the numbers and percentage of each ethnic group within Greater Glasgow and Scotland.

	GREATER GLASGOW		SCOTLAND	
ETHNIC GROUP	**No**	**%**	**No**	**%**
White Scottish	767,351	88.5	4,459,071	88.1
Other white British	31,384	3.6	373,685	7.4
White Irish	15,531	1.8	49,428	1.0
Other White	13,566	1.6	78,150	1.5
Indian	6,564	0.8	15,037	0.3
Pakistani	17,964	2.1	31,793	0.6
Bangladeshi	295	0.03	1,981	0.04
Other South Asian	2,417	0.3	6,196	0.1
Chinese	4,912	0.6	16,310	0.3
Caribbean	366	0.04	1,778	0.04
African	1,379	0.2	5,118	0.1
Black Scottish or other Black	271	0.03	1,129	0.02
Any Mixed Background	2,623	0.3	12,764	0.3
Other Ethnic Group	2,527	0.3	9,571	0.2
ALL PEOPLE	**867,150**		**5,062,011**	

The 2001 census figures excluded then current asylum seekers. Estimates indicate that since the census there are approximately 5600 currently seeking asylum in Glasgow. The number of former asylum seekers residing in Glasgow is unknown.

Map 1 below shows the distribution of BME people within Greater Glasgow by postcode sector. This ranges from less than 1% in areas such as Eaglesham, Nitshill, Pollok, the Clydebank area, parts of Milngavie, and the east end of Glasgow (Easterhouse, Parkhead and Shettleston) to over 20% in areas such as Woodlands, Dumbreck, South Kinning Park and Pollokshields. Strathbungo has the largest BME community in Greater Glasgow at 37.6%.



The 2001 Census ethnic group question recorded each persons perceived ethnic group and used 14 groups including an 'Other Ethnic Group' category to describe Scotland's population.

Some of the main findings from the Greater Glasgow analysis are:

- Greater Glasgow has the largest Black and Minority Ethnic (BME) population in Scotland (4.5% or 39,318 people)

- 38.7% of the total Scottish BME population live in the Greater Glasgow area, and 45.7% of all BME people in Greater Glasgow are Pakistani

- The BME population is younger than the White population (29.5% under 16 compared to just under 19% for the White groups)

- People from BME communities are more likely to be married than those from the White groups (53% and 38% respectively) and have larger families (29% had 3 or more dependent children compared to 14% of White people)

- BME people have a more positive view of their general health than the White population (91% compared to 86%)

- Greater Glasgow residents are more likely to live in a flat, maisonette or apartment compared with Scotland (49% vs. 29%), and a higher proportion of BME people in Greater Glasgow live in a flat than those from the White groups (56% vs. 49%)

- A higher proportion of BME households are overcrowded compared to White households (32% and 18% respectively)

- People from BME communities are less likely to be economically active than those from the White groups. However, those that are economically active are more likely to describe themselves as managers and senior officials and be self-employed

- There are substantial differences in educational attainment e.g. 50% of Africans possess a degree whereas 44% of Pakistanis have no qualifications.

10. The Race Equality Scheme

10.1 Assessing Functions

In 2002, NHSGG comprised of 5 separate, legally accountable organisations – Greater Glasgow NHS Board, Yorkhill NHS Trust, South Glasgow NHS Trust, North Glasgow NHS Trust, and the Primary Care NHS Trust. Within the NHSGG system a decision was made that each of these organisations would have its own Race Equality Scheme and associated action plan based on identification and assessment of functions. This decision was reached due to the separate legal status of the organisations, and the desire to ensure local ownership of the race agenda. It was reorganised however that much of the work within the action plans would be similar, consequently nine cross-cutting themes were identified for collaboration on a whole system basis. These themes are interpreting, advocacy, training, employment, information, research, communication, listening to communities and catering. A further two themes were added in 2004/05 – complaints and procurement.

In April 2004, following new NHS policy guidance, NHSGG became a 'unified' Board – a single legally accountable organisation for Greater Glasgow. Over the past 18 months, NHSGG has undergone a major internal re-organisation through which new organisational structures are coming into place. The details of which are still being evolved, as is the process for filling the senior posts in these structures. Consequently revisiting the assessment of functions will be undertaken during 2006/07. Details of the new structure are included in Appendix II. The functions of NHSGG will be:

- Capturing information on illness, health and well-being of the resident population.
- Corporate planning and policy.
- Planning and reviewing services that impact on the health of the local population.
- Working in partnership with statutory, voluntary, community and commercial organisations to improve the health of the local population.
- Performance managing services commissioned either directly or through partnership approaches.
- Employing staff.
- Ensuring financial governance of the organisation.

As part of the restructuring process a short life working group of inequalities identified deficiencies within NHSGG in its capacity to respond effectively and systematically to the health effects of inequality and the needs of diverse populations. A key recommendation was the need for a more corporate approach to addressing inequalities supported by a headquarters based Corporate Inequalities Team. The conclusions of the working group report reflects the experience of implementing the Race Equality Schemes/Race Equality Action Plans in that whilst there has been significant progress in specific areas, efforts to mainstream race equality into policy, practice and performance management have been patchy.

The remit of the Corporate Inequalities Team which has now been established includes the development of policy, managing the legal requirements of public sector duties of current and impending equalities legislation, developing a planning and performance management framework, and supporting the development of new, effective methodologies for changing practice. The posts within the new unit cover race and faith, gender and sexual orientation; disabilities; and socio-economic inequalities.

During 2004/05 a series of race impact assessments were conducted. The Acute Division undertook a comprehensive programme of rapid race impact assessments and identified an interim set of priorities for conducting full impact assessments. The Primary Care Division undertook a similar exercise. In addition comprehensive equality impact assessments were carried out on the existing Food and Health Strategy and the Smoking in Health Services Policy. These will be subject to further development in 2006.

10.2 Codes of Practice

In relation to the CRE Codes of Practice and in response to the patchy progress made by NHSGG to the mainstreaming of the inequalities agenda as highlighted above, the Corporate Inequalities Team is being established to systemise NHSGG's approach to inequalities, and to build on previous work undertaken. This work includes

- Contribution to the development of National Standards for Community Engagement.
- Establishment of NHSGG's Involving People Committee which oversees the governance of communities involvement in NHSGG processes.
- Development of an Equality Impact Assessment Tool with NHS Lanarkshire and NHS Ayrshire & Arran.
- Extensive piloting of rapid race impact assessments in the acute and primary care divisions of NHSGG.

  Details of the structure and methods for progressing this work will be made available during 2006/07, and will include

  - Frameworks and processes for impact assessment and consultation
  - Information on publishing results of assessment, consultation and monitoring
  - Ensuring public access to information and services
  - Training of staff in relation to race equality, anti-discriminatory practice and cultural competence as appropriate to their role
  - Development of inequalities sensitive practice.

Compliance with the employment duty will be delivered through the HR Directorate of NHSGG. The profile of the workforce will be monitored on ethnic origin, sex, age and disability as standard practice on all new employees. Work will continue to capture this information on existing employees. The composition of the workforce will be reported on, without breaching confidentiality in the annual workforce profile.

In addition ethnic monitoring will take place on applications for employment and promotion, training and training received, performance appraisal, grievances and harassment, disciplinaries and staff leaving employment. The monitoring information will be used to support the assessments of the impact of GGNHS Board's employment policies and procedures and the results of the monitoring will be published in the Annual Workforce Profile.
Consideration and planning around ethnic monitoring information will take place within the HR Directorate and form part of workforce planning developments.

10.3 Future Actions

NHSGG has established a substantial portfolio of work in relation to race equality and BME health issues. This work is detailed in the report on race equality action 2002/2005 and its appendices. The cross-cutting themes which form the basis of much of NHSGG's approach to ensuring race equality will continue.

10.3.1 **Interpreting**

- Continue to monitor progress and improve the quality of interpreting support. (ongoing)
- Publicise the availability of interpreting support to BME communities. (2006)
- Expand the availability of telephone interpreting support – initially for emergency situations in accident and emergency, and maternity sites throughout NHSGG. (2006)

10.3.2 **Advocacy**

- Recommissioning of BME advocacy services in light of independent evaluation. (2006)

10.3.3 **Training**

- Co-ordinate equality and diversity programmes including training resources/curriculum material across NHSGG.
- Market and communicate information on training programmes across the NHSGG workforce through ongoing programmes of awareness and continues to monitor the number of staff trained.
- Evaluate the effectiveness of training on local practice.
- Develop training programmes that support health inequalities and improvement functions; impact assessment training for managers.

10.3.4 **Employment**

- Work toward a single system for capturing employee details including monitoring across equality spectrum. (ongoing)
- Analyse and utilise the workforce information in workforce planning. (ongoing)

10.3.5 **Research**

- Continue to review and implement NHSGG's research strategy. (ongoing)

10.3.6 **Information**

- Establish structures and procedures to implement ethnic monitoring across NHSGG.

10.3.7 **Communication**

- Further develop the draft Communication Strategy to target BME communities. (2006)
- Development and sharing of support materials for staff considering translating information. (2006)

10.3.8 **Listening to Communities**

- The Involving People Committee will review policies and practice associated with Patient Focussed Public Involvement and consider the best ways to involve BME communities. (2006)

10.3.9 **Catering**

- Develop an action plan to audit the success of the new Halal menu.
- Resolve/conclude the provision of Kosher meals.
- Ensure issues concerning the provision of ethnic minority meals from impact assessments carried out throughout the new Acute Division are included in this action plan.
- Investigate with public partners diets for dysphagic patients (i.e. provision of pureed food).
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10.3.10 **Complaints**

- Implement monitoring arrangements and publish the results.
- Implement the marketing of the complaints procedure into BME communities.
- Provide communication support to the person making the complaints eg. ensuring the availability of advocacy services and access to interpreting support.
- Include complaints in staff race equality training.

10.3.11 **Procurement**

- Race impact assess the procurement function within NHSGG and develop and action plan.

11 Overall Challenges

Mainstreaming race equality within the context of the changing legislative and policy landscape offers substantial challenges for NHSGG, alongside the major re-organisation exercise that took place in 05/06.

A short life working group on inequalities identified deficiencies within NHSGG in its capacity to respond effectively and systematically to the health effects of inequality and the needs of diverse populations. Their report reflects the experience of implementing the Race Equality Scheme/Race Equality Action Plans in that whilst

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Towards the end of 2005 NHSGG agreed to establish a Corporate Inequalities Team with a remit for developing policy; managing the legal requirements of public sector duties of current and impending equalities legislation; developing a planning and performance management framework; and supporting the development of new, effective methodologies for changing practice.

(In taking this agenda forward, the main challenges to NHS Greater Glasgow and Clyde will be:

- Ensuring NHSGG&C complies with race relations legislation within the emerging equality and diversity agenda.
- Ensuring that the 'one system' model continues to maintain a focus on race equality through balancing overall accountability with local ownership for action.
- Harmonising approaches to policy, planning and performance management across Greater Glasgow and Clyde.
- Demonstrating a 'step change' in NHSGG&C's race equality work through the work of the Corporate Inequalities Team.
- Further developing the capacity of black and minority ethnic communities to engage with and influence the planning and review of health related services either solely within NHSGG&C or in partnership with others.
- Joining up work with other partners for the provision of direct services to black and minority ethnic communities or for the purpose of learning across organisations.