The National Black and Minority Ethnic (BME) Community Health Development Project

The Fife Report

Report prepared by REACH Community Health Project in strategic partnership with Black and Ethnic Minorities Infrastructure in Scotland (BEMIS)

January 2007

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- Dr Daksha Patel
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REACH Community Health Project and Black and Ethnic Minority Infrastructure in Scotland (BEMIS) would also like to thank all those who took the time to participate in the consultation meetings and who informed this research.

REACH Community Health Project has been an innovator in the voluntary sector through its development of a triangulated approach to the health needs of the BME (Black and Minority Ethnic) community at both strategic and grass root level, i.e.:

1) delivering culturally sensitive services to local BME communities,
2) undertaking participatory action research with local BME communities, and
3) providing cultural diversity training to health care service providers working with and in BME communities

All of the above are achieved within a framework of active initiatives to raise awareness about disadvantages for the BME communities in terms of health, as well as active promotion of race equality issues among stake-holders in relation to health.

BEMIS is the only black led national umbrella and intermediary body representing and supporting the development of the black and minority ethnic voluntary sector across Scotland, supporting the diverse communities and individuals that this sector represents especially those under-represented and disadvantaged.

BEMIS recognises that we work in a context of inequality. It aims to redress these inequalities by empowering communities. BEMIS works towards an inclusive society by establishing structures that recognise and promote diversity and empowers the black and ethnic minority communities and sector across Scotland.

CONTENTS

Executive Summary

Introduction

1. The National Black and Minority Ethnic (BME) Community Health Development Project was launched in December 2006 by REACH in partnership with BEMIS (Black and Ethnic Minority Infrastructure in Scotland). The project is funded through the Scottish Executive's 'Race Equality, Integration and Community Support Fund' managed by the Voluntary Action Fund, and is working with the following Health Boards within NHS Scotland:

- Fife
- Highland

2.REACH Community Health Project has been an innovator through its development of a triangulated approach to the health needs of the BME communities in Glasgow namely,

a. delivering culturally sensitive ***health services*** to local BME communities
b. undertaking ***research*** into the health needs of BME communities, and
c. providing ***cultural diversity training*** to health care service providers working with and in BME communities.

REACH, with the strategic support of BEMIS, has been funded to investigate the transferability of this approach to a Scottish context, working directly with Health Board staff to develop a positive partnership between mainstream services and the voluntary sector[1] with the aim of improving health services to ethnic minority communities.

3. This report is based on an assessment, undertaken by the BME National Community Health Development Officer over a six month period, of the status of health delivery services available to ethnic minority communities within NHS Fife. A key focus of this study is an assessment of racial inequality and disadvantage in relation to the delivery of health services.

This involved the following activities:

a) a literature review of key strategic policy documents, and of research relevant to the health needs of BME communities ,
b) mapping existing health services for ethnic minority communities in Fife,
c) mapping cultural diversity training available to health care providers,
d) and consultative workshops with mainstream, voluntary sector and BME community representatives.

4. The purpose of this report is to inform NHS Fife representatives and other key stakeholders on its main findings, and to discuss recommendations in relation to an action package aimed at developing:

a) Area-specific research agendas
b) BME community health preventative services, and
c) Tailor-made cultural diversity training programmes.

The report also identifies ways in which REACH in partnership with NHS Fife might provide input at both a strategic and operational level in support of this action package.

[1] referred to in UK Government policy reports as the Third Sector

Project Context

5. Relevant to this project has been the significant growth in the BME population in Fife, a growth which is disproportionate to the rest of the population. Fife has an increasingly diverse community with the influx of migrants, who are generally younger workers from Eastern Europe. This is combined with the younger demographic profile characteristic of established BME communities in the UK.

6. Legislation at both a UK and Scottish level requires NHS bodies, under their general duty as set out by the Race Relations Amendment Act (2000), to eliminate unlawful racial discrimination, to promote equality of opportunity, and to promote good relations between people of different racial groups. This project aims to support NHS Fife in meeting its obligations under the Act, namely to actively consider how it will offer the same health and well being opportunities to BME communities in Fife as it does to the rest of the population.

7. REACH, in partnership with BEMIS, FRAE Fife the local BME network organisation, and other third sector health organisations in Fife, is interested in being involved in discussions with NHS Fife on how to support the implementation of policies and operational plans at a grass roots level through sharing expertise in involving BME communities directly in designing and delivery of services.

Main Findings and Conclusions

8. There is a lack of quantitative and qualitative health data on BME communities in Fife. Public health datasets do not include specific data on Fife's BME communities. This gap in data precludes service design and planning of inclusive mainstream services which address the specific health needs of Fife's BME communities. .

9. There does not appear to be any NHS Fife policy or strategy specifically designed to address the health needs, and delivery of health care, to BME communities. . Only the new Joint Health Improvement Plan consultation report actively considers different 'communities of interest' including BME communities. However the latter appears to be considered as one homogenous 'community of interest'.

10. There is currently only one mainstream service specifically designed for BME communities. This is a health advocacy project, developed and co-ordinated by Dr Patel of NHS Fife, who is seconded to work on a part-time basis with FRAE Fife. This service includes the delivery of screening services for diabetes, blood pressure monitoring, and food and nutrition advice, on an ad hoc basis at different ethnic minority community events. This is not however part of any strategic approach to meeting unmet health needs within Fife's BME population.

11. There has been limited race equality and cultural diversity training provided to NHS Fife employees. The training provided is in the main generic equality training:

- training for managers is on general equality and diversity issues;
- the proposed two and half day training course for a limited number of primary care staff will cover equality and diversity, but not specifically race equality;
- doctors, dentists and pharmacists, do not currently have continued professional development courses that cover duties under race equality legislation, or of health needs and health inequalities of BME communities and if such courses did exist it's felt that this would be optional and not mandatory.

Recommendations and Proposed Action Plan

12. **Area-Specific Research Agenda**

The lack of quantitative public health data on BME communities in Fife plus qualitative data on health concerns will require a comprehensive and strategic approach to identifying and sourcing public health data and commissioning research to identify specific health needs of different sections of the BME communities in Fife, taking into account data on national prevalence rates and specific health risks.

REACH will contribute to this through:

- publication of a guide for NHS staff on key academic research on health inequalities experienced by members of diverse BME communities. .
- support for the application of participatory action research methodologies which build and support social and community participation by members of BME communities. .
- Advice on the development of performance measures for assessing the impact of operational plans in terms of addressing access to services by BME communities .

13. **The Design of Community Health Prevention Services for BME communities.**

The Joint Health Improvement Planning process of NHS Fife provides an opportunity to explore how community health prevention services might be developed and promoted among BME communities in Fife as part of mainstream delivery of services e.g. in relation to HIV and Aids, mental health problems, diabetes, coronary heart disease, cancer etc.

REACH has through its success in the development of a community health clinic in Glasgow identified core elements to preventive health services delivered to BME communities in community settings, providing the types of services that meet a broad range of health needs. It is proposed that this model, developed by REACH, is piloted in Fife by NHS Fife public health department in conjunction with local BME community organisations.

This pilot will also act as a resource to voluntary agencies in promoting provision by them of accessible services which meet the following equality criteria: - equal *access via appropriate information; access to services that are relevant, timely and sensitive to the person's needs; and being able to use the service with ease and having confidence that you will be treated with respect."*[2]

[2] Atkinson M, Clark M, D Clay, et al. Systematic review of ethnicity and health service access for London. Conventry:Centre for Health Services Studies, University of Warwick.

14. **The Planning and Delivery of a Cultural-Diversity Training**

NHS Fife is keen to meet its duties as defined in legislation and NHS Scotland guidance. However the generic programme of training in equalities issues is not sufficient to raise awareness of employees in terms of the following:

- legislative duties and service standards in relation to BME communities
- specific health needs and causes of health inequalities

The recommended emphasis is not so much on compliance but instead raising awareness of the underlying rationale for legislative requirements and the design of services which will meet performance standards in relation to different sections of the BME population.

15. In terms of future direction of The National Project the following is proposed:

- In the next phase REACH in partnership with BEMIS will begin to work with NHS Highland. And as part of this work will consider the impact that the strategy to address racial inequalities has had on the level and type of activities, and the rate of capacity building within Highland's public health and primary care services in terms of addressing health inequalities experienced by BME communities in the Highland area.
- REACH will also consider the benefits to primary care of the Culture Diversity Training offered by NHS Highland and will explore evidence that health care professionals as well as support and administrative staff are accessing this resource.

SECTION ONE

INTRODUCTION
Background to the Review

1.1 On the 16th June 2006 the then Communities Minister Malcolm Chisholm announced the allocation of £2 million Race Equality, Integration and Community Support Fund (REICSF) to support race equality work by locally based projects involved in supporting cross community integration, helping organisations and communities to tackle racism and to promote equality. BEMIS and REACH were jointly awarded a grant to investigate the transferability of lessons from REACH's local health project in Govanhill (south Glasgow) to a Scottish context.

1.2 In March 2007 BEMIS published its research into the engagement of public sector agencies in Scotland with BME communities.[3] Two health boards, both rural, took part in this review, along with police forces and local authorities. The study found that in general public agencies committed to involving service users in the reviews of services at all levels, and in tackling community needs and concerns, are still in the minority. Improvements are needed through joint work by public sector agencies with BME communities on an individual service user basis as well as with representative structures.

1.3 In May 2007 REACH Community Health Project published research into the health experiences of black and minority ethnic (BME) young people in the south side of Glasgow and their perceptions of barriers to accessing health care and information on health risks.[4] REACH has been an innovator through its development of a triangulated approach to the health needs of the BME communities in Glasgow namely,

a. delivering culturally sensitive ***health services*** to local BME communities
b. undertaking ***research*** into the health needs of BME communities, and
c. providing ***cultural diversity training*** to health care service providers working with and in BME communities.

1.4 REACH in conjunction with BEMIS is interested in extending this approach to its direct work with health service providers. The four aims of the BME National Community Health Development Project in relation to health service delivery to the BME community are (see appendix one – aims and objectives) :-

Aim 1: To establish the evidence of racial inequality and disadvantage;
Aim 2: To improve the provision of services and support to BME communities;
Aim 3: To drive up public sector performance on race equality and improving access to, and benefit from, public services;
Aim 4: To develop the awareness and capacity of both majority and minority communities to engage with this agenda, to tackle racism, and to promote race equality.

[3] A review by BEMIS of Engagement by Public Sector Agencies in Scotland with Ethnic Minority Communities (Jan 2007)
[4] REACH (May 2007) *The Health Needs of Black and Minority Ethnic Young People living in the South Side of Glasgow*

1.5 The SRIF grant enabled REACH to work in two Health Board areas to support work at a strategic and operational level around the reduction of health inequalities and delivering equity of opportunity in terms of health and well being to BME communities. The selection of areas took account of differences in the relative numbers of different BME communities between urban and rural areas of Scotland. The two Health Boards chosen were Fife and Highland. Each offered opportunities to consider different types of challenges to the design and delivery of services.

1.6 The first area selected for REACH to work in was NHS Fife. One focus of the study was how, as Fife's BME population continues to grow and become more diverse, NHS Fife is going about mainstreaming race equality. This is a challenging agenda, in terms of achieving a balance between social cohesion and the rights of individuals to equity of access to health services, considered central to developing an inclusive society.

1.7 In order to make the project manageable it was decided to focus the investigation on Primary Care Services, given that 90% of patient contact with healthcare services is in primary care.[5]

1.8 This work was informed by the following principles underpinning services that specifically consider BME communities.

- The ethical context: every individual has the right to equality of opportunity to health and well being. British society has reflected this principle in its legislative framework;
- The legal context: under the Race Relation Act 1976 as amended by the Race Relations Amendment Act (2000) health boards have the duty to eliminate unlawful discrimination, to promote good relations between different ethnic groups, and to offer equality of opportunity to care;
- The business context: It is to the benefit of Scottish society and our economy if everyone has equality of opportunity to enjoy maximum health and well being. This will facilitate the ability of the whole population to maximise the potential to contribute in whatever ways it chooses.

Approach

1.9 The project was jointly developed by REACH and BEMIS in partnership with FRAE Fife. A key focus of the project was consideration of health service provision from different BME communities' perspectives. Through a network of BME grass-root groups established by BEMIS across Scotland contact was made with FRAE Fife. FRAE Fife is the umbrella organisation for BME community groups in Fife, and was extremely active in supporting this project by sharing information and contacts.

[5] Partnership for Care Scotland's Health White Paper: Point 11: Health Services in the Community, accessed at: http://www.scotland.gov.uk/Publications/2003/02/16476/18736

1.10 The following approaches were taken to collecting evidence:

a) a literature review of key strategic policy documents, and of research relevant to the health needs of BME,
b) mapping existing health services for BME communities in Fife,
c) mapping cultural diversity training available to health care providers,
d) and consultative workshops with mainstream, voluntary sector and BME community representatives.

1.11 The outputs were informed by the following:

- clinical research on health inequalities experienced by BME communities in Britain - there appears to be little evidence of significant difference between the health inequalities and health needs of BME in Scotland as compared to England;
- NHS policy at a Scottish and local level;
- performance standards informed by UK legislation;
- BME demographic data.

1.12 The aim of the literature review was to assess whether the needs of BME communities were being considered and expressly addressed in strategy documents. It therefore focused on the key corporate policy and strategic documents, produced by NHS Fife, and published on the NHS Fife's website. It considered how specific national public health policies on health needs of the BME population were translated by NHS Fife into primary care strategy. NHS Fife's corporate policy framework and public health strategies were reviewed to establish whether the needs of BME were explicitly being taken into account, and in particular in relation to addressing health inequalities.

1.13 The questions posed[6] were as follows:-

- With what population/patients is the policy or operational plan concerned?
- What ethnic minority demographic data underpins the policy or operational plan?
- Where ethnic minorities are expressly mentioned, are there specific ethnic groups being targeted or is there an assumption of homogeneity?
- Where ethnic minorities are expressly mentioned, what are the proposals for engaging them in the decision-making process?

Policy context and issues considered

1.14 ***Evidence of health inequalities and distinct health needs***

There are many factors that influence an individual's health and well being and experiences of health inequalities. Historically the measurement of health inequalities has focused on individual occupation and associated social class. However contemporary research recognises a number of additional considerations such as gender, ethnicity, age, geographic location, and religion. A Health Development Agency briefing for a recent European conference highlighted the following research findings: [7]

[6] Informed by Raj S. Bhopal: Ethnicity, Race and Health in Multicultural societies: Chapter 8. Oxford Press: 2007.

[7] Hilary Graham, Professor of Social Policy, Institute for Health Research, Lancaster University, and Michael P Kelly, Director of Evidence and Guidance, Health Development Agency, London *'Health Inequalities :concepts, frameworks and policy'*. Presented to NHS Health Scotland European Conference: 'Closing the Gap: strategies for action to tackle health inequalities in Europe', February 2007.

"Research suggests that socio-economic disadvantage is a major contributor to the poorer health of African–Caribbean, Bangladeshi and Pakistani groups, and exposure to racism is an important part of why they are more disadvantaged than the wider population.[8] In addition there is evidence that racism takes an additional toll on the health of Black and Asian communities.[9]"

The Scottish Executive report on the 2001 Census[10] along with other NHS data provides evidence of social-economic and health inequalities:

- Unemployment is twice as high for the ethnic minority population (15%) as compared to the white population (7%);
- 30% of Pakistani, Bangladeshi and African people experience overcrowded living conditions compared to 7% of White Scots;
- 40% of Pakistanis over 60 years describe themselves as having ill health compared to 22% of White Scots;
- and Gypsy /Traveler women live 12 years less than settled women and men 10 years less than settled men.

1.15 As noted by the Runnymeade Trust the ability of health services to influence equality of opportunity requires the recognition of real differences, and then delivery of appropriate services in a culturally competent manner to meet identified needs.

"People must be treated equally, but with also with regard to real differences of experience, background and perception, and the need for common values and social cohesion."[11]

The need for a strategic approach was identified as part of the findings of the Fair for All Stockade in 2002.[12] In order for people from an ethnic minority background to experience equality of healthcare, their health needs require to be taken into account by those setting health strategies and priorities at a local Health Board level.

"Health needs assessment is important to the achievement of the patient-centred and equity–orientated goals of modern health care systems in multi–ethnic societies, and to the narrowing of the inequalities in health…"[13]

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[8] Nazroo,J.Y.(2003) The structuring of ethnic inequalities in health: economic position, racial discrimination and racism, as quoted in HDA Briefing document: Health Inequalities: concepts, frameworks and policy.

[9] Karlsen, S. and Nazroo, J.Y. (2002) The relation between racial discrimination, social class and health among ethnic groups. American journal of Public Health 92:624-31, as quoted in HDA briefing document: Health Inequalities :concepts, frameworks and policy.

[10] Scottish Executive (2004):Analysis of ethnicity in the 2001 Census: Summary Report

[11] Runnymeade Trust (2002) *The Future of Multi- ethnic Britain, The Parekh Report*, p 106,

[12] Fair for All (2002) http://www.scotland.gov.uk/library3/society/ffar-00.asp

[13] Raj S Bhopal (2007), *Ethnicity, race and health in multicultural societies*, chapter 5 p 116. Oxford University Press.

PLANNING TO INCLUDE BME: HEALTH NEEDS ASSESSMENT OF BME PEOPLE
Evidence of health states, disease patterns health care utilization*   **↓**   **Comparison with the white group and other minority ethnic groups.***   **↓**   **Qualitative research that consider perceptions, attitudes and beliefs. ***   **↓**   **Design appropriate services, to address the needs identified. As part of this process acknowledge real difference in health needs of different BME people and in so doing seek to eliminate health inequalities.**   **↓**   **Deliver appropriate health care services in a culturally competent manner**
*Adapted from Prof Raj Bhopal. Chapter 5, Race Ethnicity and Health in Multicultural society.

1.16 For many different BME groups there are increasing clinical evidence to support the recognition of real differences that exist in relation to health needs.

> "*The risk of being registered with Type 2 Diabetes after adjusting for sex and age is eight, four and three times higher in Pakistan, Indian and Chinese ethnic groups respectively, compared with the majority white population."*[14]

There is also increasing evidence of differences between different BME groups in relation to health conditions, and therefore BME cannot be considered as a homogenous group. Research by the Policy Research Institute on Ageing and Ethnicity (PRIAE) on BME Elders published in 2005[15], found that there were differences in the incidence of various health problems among elders in different BME groups. In relation to serious health problems the main differences were:

- *African-Caribbean elders have a higher incidence of high blood pressure than South Asians who, in turn, had a higher incidence than Chinese/Vietnamese elders;*
- *African-Caribbean and South Asian elders have a higher incidence of diabetes than Chinese/Vietnamese;*
- *Heart disease and lung/breathing conditions are highest amongst the South Asians;*
- *Osteoporosis and memory problems are highest amongst the Chinese/Vietnamese.*[16]

[14] A Report by the National Resource Centre for Ethnic Minority Health in collaboration with the Scottish Diabetes Group. Diabetes in Ethnic Minority Groups in Scotland, Full report 2004, accessed at: http://www.nrcemh.nhsscotland.com/pdfs/Full%20Diabetes%20Report.pdf

[15] '*Black and Minority Ethnic Elders' in the UK: Health and Social Care Research Findings',* http://www.priae.org/docs/MEC%20UK%20%20Summary%20Findings.pdf
PRIAE Policy Research Institute on Ageing and Ethnicity 2005,ISBN 09537642-4-9
Published by PRIAE sponsored by the Department of Health

[16] Black and Minority Ethnic Elders' in the UK: Health and Social Care Research Findings:

1.17 Differences between BME groups are also found among recent migrant groups from Eastern Europe. The impact on statistical results which ignore variances within BME groups results in the failure to identify specific health needs. This is increasingly the case as the relative numbers of East Europeans in comparison to the established BME communities begin to skew results in many parts of Scotland.

1.18 In addition to considering differences between different BME groups, it is also relevant to consider gender differences in relation to health needs and the delivery of health care services. Understanding how this research translates into policy and into the design of services to address health inequalities is the focus of this project.

Ethnic monitoring and meeting health inequalities

1.19 Challenging health inequalities requires a partnership approach. The restructuring within primary care that has happened over the last two years in establishing Community Health Partnerships is part of the commitment by NHS Scotland to creating a more integrated approach to the delivery of health and well being, with social work and primary health care services developing closer working arrangements. The development of joint health improvement planning processes also reflects the awareness of the impact of socio-economic factors on health inequalities, and commitment to the development of joint aims and objectives by local authorities and NHS boards.

1.20 For strategic planning to be effective there is a need for up to date shared knowledge. This has been developed in the form of public health datasets, which provide a range of information on the general population, broken down by age and gender in relation to education, training, skills, lifestyle and behaviour, income and prosperity. There is currently no break down by ethnicity. This presents serious challenges in relation to public health planning for the BME population in Scotland.

There are several initiatives now beginning to address this issue, including:

- Professor Raj Bhopal's report in 2005 on *"Ethnicity and health in Scotland: can we fill the information gap?"* This project was funded because of the recognition of the impact of continuing lack of data.
- ISD Scotland has an ongoing diversity and equality project to support and encourage ethnic monitoring in the NHS.
- The GP contract was amended to include the provision for 1 point (equivalent to £145) to be awarded when 100% ethnic monitoring of new patients was achieved.
- The National Resource Centre for Ethnic Minority Health (NRCEMH) in conjunction with Health Scotland, has created tools that will support the collection of ethnicity data, with both a communication strategy for the implementation of ethnic monitoring and an ethnic monitoring toolkit.[17] However the lack of an easy IT interface within G-Pass to input this data and a lack of training with front-line staff have undermined the usefulness of these tools.

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http://www.priae.org/docs/MEC%20UK%20%20Summary%20Findings.pdf

ISBN 09537642-4-9 Published by PRIAE sponsored by the Department of Health

[17]© NHS Health Scotland, 2005. Ethnic Monitoring Tool :
http://www.isdscotland.org/isd/files/ETHNIC%20MONITORING%20TOOL.pdf

1.21 The lack of data on existing patients' ethnicity within the primary care setting impacts negatively on the following:

- At a strategic level - the ability to plan and target health inequalities experienced by BME communities ;
- At an operational level - ensuring that services are accessible and BME communities are informed about services, and that race equality impact assessments are implemented;
- At a NHS employee level - ensuring that staff are well informed and knowledgeable about health challenges and quality of health access issues for BME clients; that they are supported in actively searching for, and commissioning research; and that they are supported in pursuing performance outcomes in support of BME clients.

1.22 The NHS is now mainstreaming race equality across all its services. This means that all primary care health services are aspiring to meet the needs of BME clients as part of their mainstream process and procedures. However without baseline ethnicity data of local communities and patient lists it is not possible to actively target patients who may have specific needs such as CHD, Diabetes, Hypertension, Stroke, and mental health. For example within dental services the new IT system currently being rolled out across Scotland for community dentistry does not have a field for ethnicity. Such data is part of the mandatory data sets for the preventative dentistry programme for young children - Child Smile, but has not been collected.

As a result it is challenging for primary health care and health boards to demonstrate that they are meeting their obligations, and offering equality of opportunity, and it is a challenge for the individual BME person to be aware of their rights in terms of equality of opportunity to health services.

1.23 There is in addition the issue of faith. In a recent article in the BMJ, Professor Aziz Sheikh argued for consideration of health needs of faith based groups:

> *"Muslims have the poorest overall health profile in Britain, but there are few faith-centred initiatives aiming to improve health outcomes for our largest minority faith community…."*[18]

If primary health care were to consider a faith-based approach to the targeting of services for patients, they would find their lack of data on patients' religions and beliefs was a barrier to assessment of health outcomes.

Access barriers to mainstream services

1.24 However, even with such data supporting the planned and targeted delivery of preventative health information and screening services to BME communities, there may not be the expected uptake of services. This may be the result of cultural and language barriers within mainstream services. This issue was highlighted by REACH's own research *The Missing Link*[19], and also in the report by NRCEMH in 2004 on the Khush Dil Coronary Heart Disease project in Edinburgh:

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[18] Prof. Aziz Sheikh, Professor of primary care research and development at the University of Edinburgh '*Should Muslims have faith based health services*?' BMJ Jan 2007;334:74. http://www.bmj.com/cgi/content/extract/334/7584/74

[19] REACH (Sep 2004) *'The Missing Link: Black and Minority Ethnic Community Participation in Health'*. http://www.reachhealth.org.uk/policies/research.php

"The reality of effective mainstreaming, from our *experience of working with one [non-homogenous] high risk grouping, will present major challenges. Quality frameworks that are grounded in a practical understanding of local, evidence-based experience are needed to support this process. We do not think it feasible for this to be realised without some level of targeted provision in the short and medium terms to bridge the current equalities gap and to facilitate a sensitive, phased progression into mainstream. This will need community or outreach approaches that are culturally sensitive, flexible, and accessible (run from familiar environment) and which crucially foster good relationships with the at risk community."*[20]

1.25 The existence of services, either mainstream or specialist, does not in itself provide appropriate access. A recently published article that reviewed research evidence on access to health care by BME populations identified the following dimensions of equitable access:

- *having equal access via appropriate information;*
- *having access to services that are relevant, timely and sensitive to the person's needs;*
- *being able to use the health service with ease, and having the confidence that you will be treated with respect."*[21]

1.26 REACH's report '*The Missing Link'* identified the lack of ease and confidence that many BME people have when dealing with mainstream services such as poor staff attitudes:-

- *feeling that frontline staff especially nurses and receptionists, are rude and uncaring about patient's suffering;*
- *feeling that staff may be discriminating against them based on skin colour and language - perception that staff treat people better if they spoke English."*[22]

The Scottish policy context

1.27 The Scottish Executive has a clear and well-established commitment through *Towards a Healthier Scotland*,[23] *Building a Better Scotland*[24] and *Our National Health: A plan for action, a plan for change*[25] to improving health and shifting the emphasis away from ill-health to one that focuses much more on prevention and health improvement. As part of that commitment, and aligned with the Executive's strategies for promoting social justice and closing the opportunity gap, there is a particular focus on tackling health inequalities as the 'overarching aim' of the health improvement agenda.

[20] Case Studies for Change: Community Development :http://www.nrcemh.nhsscotland.com/Tools/Case%20Studies%20for%20Change/Case%20Studies%20for%20Change.pdf

[21] Atkinson M Clark M, Clay D, et al (2001) '*Systematic review of ethnicity and health service access for London &.Coventry*', Centre for Health Services Studies, University of Warwick.

[22] REACH (2004) ibid.

[23] *Towards a Healthier Scotland*. Scottish Office, 1999

[24] *Building a Better Scotland*, Scottish Executive, 2002

[25] *Our National Health: A plan for action, a plan for change*, Scottish Executive, 2000

"The commitment to improving health, integrated with the pursuit of social justice, includes the need to bridge the opportunity gap for all equally, regardless of age, gender, sexual orientation, geographical or economic position, ethnicity, disability or faith."[26]

In 2001 *Our National Health: A Plan for Change*, committed the Executive to requiring NHS Boards:

"to ensure that NHS staff are professionally and culturally equipped to meet the distinctive needs of people and family groups from ethnic minority communities."[27]

This statement reflects the recognition that the NHS, at the point of delivery, should be delivering services in a 'culturally competent' manner.

1.28 In addition to mainstream policies there is specific Scottish research that has informed local policy development. The '*Fair for All'* stockade report highlighted that although the intentions of health boards were positively stated, in relation to considering health needs of BME people this was not evidenced by their approach and prioritization of strategic plans and actions.

Performance standards informed by legislation

1.29 The foundation for this is the 1976 Race Relations Act, which established the principle of racial discrimination. This has been further developed as a result of the Stephen Lawrence Inquiry, which informed the creation of the Race Relations (Amendment) Act (2000). When applied to the NHS as a public body delivering services, the legislation demands that it meets the standards now set out as the General Duty in the Race Relations Amendment Act (2000), namely:

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

1.30 In order to support the effective implementation of their legislative duties as regards health care delivery the Scottish Executive Health Department has taken steps to create tools that will assist Health Boards to achieve the expected legal standards – an example of this, as mentioned previously, is the ethnic monitoring toolkit developed by NRCEMH.[28] This resource centre was created by the Scottish Executive to support Scottish NHS Boards in meeting these standards. The combination of mandatory race equality schemes and action plans, with the variety of toolkits made available to support and facilitate the designing and collection of information and data, provides a strong framework for organisations to develop and actively deliver change over a period of time. However the political and organisational culture at a local level is equally powerful determinants of achieving real progress.

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[26] Improving Health in Scotland - The Challenge 2003.
http://www.scotland.gov.uk/Publications/2003/03/16747/19932

[27] Quoted *in'Audit of Research on Minority Ethnic Issues in Scotland from a 'Race' Perspective',* Gina Netto, Rowena Arshad, Philomena de Lima, Fernando Almeida Diniz, Martin MacEwen, Vijay Patel and Rana Syed.

[28] [28]© NHS Health Scotland, 2005. Ethnic Monitoring Tool
:http://www.isdscotland.org/isd/files/ETHNIC%20MONITORING%20TOOL.pdf

Institutional racism and individual prejudice

1.31 One of the barriers to challenging health inequalities, despite policies designed to address the inequalities and the setting of legal standards, is institutional racism. There continues to be misunderstandings about this. The editorial article '*The Prejudices of Good People'* explains:

> *"Most people wrongly believe that this means that everybody in an institution is in some way overtly or unconsciously a racist. However, the most important point about understanding what* ***institutional racism*** *means in an organisation such as the NHS is how processes, structures, and values operate to disadvantage black and ethnic minority patients and staff. It is unwitting prejudice, ignorance, and thoughtlessness that lead to* ***institutional racism."***[29]

1.32 The initiatives that the NHS is seeking to implement to challenge health inequalities must be set in the context of the wider Scottish environment and racism. While frameworks are being developed such as *One Scotland Many Cultures*, it is the awareness, knowledge, attitude, skills and commitment of people in positions of decision making that facilitate the delivery of meaningful change. And the decision maker with reference to most service users tends to be frontline staff.

The most recent information on racial harassment and race crime was reported in March 2007 with such crime increasing by 13%, and more than 5,000 incidents recorded by police last year.[30] The Scottish Executive website,[31] *One Scotland, No Place for Racism Attitudes today*, highlights that:

- 56% of Scots feel there is 'a great deal' or 'quite a lot' of prejudice towards ethnic minority communities in Scotland. *(Source: Attitudes to Discrimination in Scotland 2003)*
- One in every 25 Scots acknowledge that they have perpetrated racist abuse. *(Source: System 3 Summary of Anti Racism Campaign Surveys, June 02)*

There is a constant reminder of the harassment and violence that many BME people experience in Scotland in daily newspapers. And the impact of the media to influencing attitudes is often subtle as they reinforce stereotypes and assumptions with emotive headlines.

This is part of the day to day environment that the NHS is working within and therefore it requires leadership and commitment to challenge negative attitudes and to mitigate their impact on effectiveness of ensuring equity of access to health care services.

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[29] Aneez Esmail, vice-president of the Medical Practitioners Union BMJ 2004;328:1448-1449 (19 June), doi:10.1136/bmj.328.7454.1448, accessed at: http://www.bmj.com/cgi/content/full/328/7454/1448

[30] BBC March 27th 2007 report accessed at: http://news.bbc.co.uk/1/hi/scotland/6498853.stm

[31] One Scotland No Place for Racism accessed at : http://www.onescotland.com/onescotland/osmc_display_leveldown.jsp?pContentID=83&p_applic=CCC&p_service=Content.show&

Changing demographics and policy priorities

1.33 Scotland's population in 2001 was over 5 million of which 2% were defined as BME communities - approximately 100,000. Since the 2001 census there are indications that the rate of increase has increased. Public bodies comment on "*the changing demographics of Scotland*" and particularly since the arrival of increased numbers of East European economic migrants. Comparisons between resident BME communities and new migrant workers and their families are important to equality impact assessments, and to the planning, designing and delivery of services.

- The profile of the BME population in Scotland is younger than the dominant white group, with the combined population having 44% of people under the age of 16 years.[32] The white/Irish population has the highest percentage of people over pensionable age.
- The profile of East Europeans is 82% fall between 18 and 34 years. And this section of the population tends to swell during the summer months. [33]

1.34 For a long time there was reluctance from the NHS in Scotland to actively consider the health needs of the BME population, particularly in areas of Scotland where there was a dispersed and diverse population. The research work by Philomena de Lima, in 2001 '*Needs not Numbers, an exploration of minority ethnic groups in Scotland',* highlighted the rights of all BME people to equality of opportunity irrespective of numbers.[34] Combined with the NHS 's legal obligations under the general duty of the Race Relations Amendment Act (2000), means that the fact there may be small 'numbers' in an area is not an acceptable reason for failing to actively promote equal opportunities. The basic standards that the general duty establishes - the development and publishing of a race equality scheme and action plan - have been met by NHS bodies, and a review of these baseline documents was carried out by NRCEMH. It has been more challenging for NHS staff to fully grasp at an operational level how policy and strategic development processes are affected by this legislation. The Scottish Executive has developed an equality impact assessment toolkit to support changes in organisational planning and development processes. It does however require knowledge and understanding of the key principles of racial discrimination, and how this operates in society at large and within the NHS, to be able to competently complete a race equality impact assessment.

1.35 Historically the needs of BME communities have been met through an expectation that they will come to services provided for the majority population, and where this is not the case there may be an ad hoc approach taken to meeting their needs rather than specifically meeting such needs as part of a strategic approach:-

> *"We can conclude, on the principle that similarities between human populations tend to outweigh differences that the general priorities of health care systems are of great importance to minority ethnic groups. Public health and health care initiatives must therefore, cater for the ethnic majority and minority population simultaneously, with work of equal potential effectiveness and sensitivity. To do*

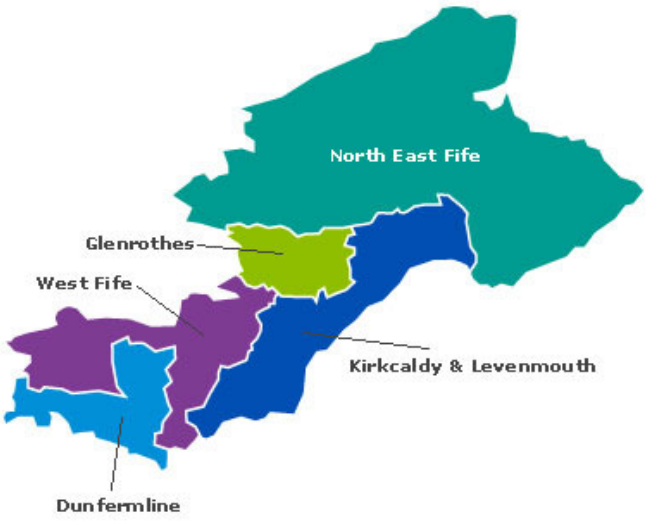
[32] Analysis of ethnicity in the 2001 Census: Summary Report
[33] Demographic Change in Scotland: COSLA Strategic Migration Partnership, http://www.asylumscotland.org.uk/asylumstatistics.php
[34] de Lima, P. (2001) *Needs not Numbers, an exploration of minority ethnic groups in Scotland,* London: Commission for Racial Equality and Community Development Foundation

otherwise promotes inequality and inequity. It is surely unethical and institutionally racist, and in some countries illegal…" [35]

1.36 ***Profile of Fife and its BME population***

Fife has a total population of approximately 350,000. It has a varied geography (popularly known as the "Kingdom of Fife") with three large towns - Kirkcaldy, Dunfermline and Glenrothes where a third of the population live - while two thirds of the population live in smaller rural settings (see map).[36] NHS Fife's boundaries are co-terminus with the boundaries of Fife Council. This facilitates close working relationships in the delivery of services.

There are three Community Health Partnerships (CHPs) providing the focus for planning delivery of primary care health services within - Glenrothes & North East Fife, Kirkcaldy & Levenmouth, and Dunfermline & West Fife. These CHPs, established in April 2005, are responsible for the delivery of health services in Fife and are partnerships between Tayside Health Board, Fife Council, voluntary sector organisations, and members of the public. Each CHP is also responsible for some Fife-wide services including Health Promotion, Mental Health, Well Woman and Family Planning Services.



1.37 Fife shows one of the largest percentage increases in BME population over the period 1991 to 2001 (see table 1). Since 2001 there has been an influx of East European migrants to this area[37] - at least 3,500 new national insurance numbers released within Cupar since 2001, predominately Polish workers, but also Estonian and Latvian. Although not all may have continued to stay in Fife, it does suggest changing demographics of the ethnic minority population living and working in Fife over a very short time period.

[35] Raj S. Bhopal: Ethnicity, Race and Health in Multicultural societies: Chapter 7.8 page 204. published :Oxford Press 2007

[36] Scottish Public Health Observatory : http://www.scotpho.org.uk/

[37] Tayside Police presentation to Fife Arabic Society.

Examples of the percentage change in numbers of black and minority ethnic people in local authorities in Scotland

Ref: Centre for analysis of social exclusion, an ESRC Research Centre.

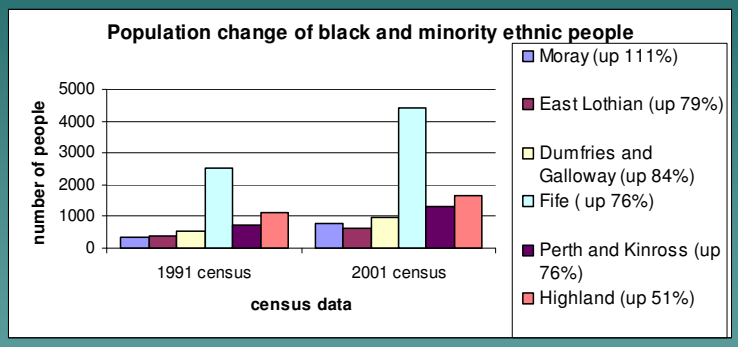


Table 1

SECTION TWO

MAIN FINDINGS AND CONCLUSIONS

Literature review of NHS Fife and CHPs strategies and reports

2.1 The corporate policy framework and the main public health strategies developed by NHS Fife were reviewed to establish if the needs of BME communities were explicitly being taken into account.

NHS FIFE LOCAL DELIVERY PLAN 2006/7

With what population/patients is the operational plan concerned?

- Most deprived populations – areas of deprivation referrals
- Parents/mothers who smoke
- Teenagers/young people/adults/ older people
- Gay, lesbian, bisexual and transgender (GLBT)

What BME demographic data underpins the operational plan?
None

Where BME communities are expressly mentioned? Are there specific ethnic groups being targeted or is there an assumption of homogeneity?
Not mentioned; no consideration of risk factors in relation to CHD – reference only to areas of deprivation.

Where BME communities are expressly mentioned, what are the proposals for engaging them in the decision-making process?
Not considered.

NHS FIFE DELIVERY PLAN 2006 - 2008

With what population/patients is the operational plan concerned?

- People from a range of disadvantaged backgrounds
- Early years / children's services / teenage transition, adults / older people
- Mental health and learning disability services
- community sector / workplaces

What BME community's demographic data underpins the operational plan?
Statement that Fife Community Plan describes the demographic trends that inform this plan.
Where BME communities are expressly mentioned? Are there specific ethnic groups being targeted or is there an assumption of homogeneity?
Not mentioned.
Where BME communities are expressly mentioned, what are the proposals for engaging them in the decision-making process?
Under the commitment to continuing to develop the organisational culture by building staff capacity in diversity and equality, there is no reference to any equalities groups – only people from a range of disadvantaged backgrounds. **BME** people are not necessarily from disadvantaged backgrounds but may be disadvantaged as a result of Institutional Racism.

Fife Community Plan (2004) – revised in 2006

With what population/patients is the community plan concerned?
Section on: "Improving Health and Well Being". The only groups that this section expressly refers to are:

- Older people
- People with disabilities.

What BME community's demographic data underpins the community plan?
No baseline **BME** demographic data - no reference to variance from the rest of population; no reference to how proportionally there is a growth of this population and that the rate of increase differs. (Note this plan was developed prior to accession of the 8 European countries, although the revised plan was revised in 2006).
The population trends highlighted are the following:

- Overall static population
- Proportion of older people is growing
- Life expectancy is increasing
- Birth rate is falling

Draft Consultation Joint Health Improvement Plan (JHIP)

With what population/patients is the JHIP concerned?

- Early years / teenage transition
- Workplace / communities
- Communities of interest

What BME community's demographic data underpins the policy/ operational plan?
Public health dataset has no information on ethnicity.

Where BME communities are expressly mentioned? Are there specific ethnic groups being targeted or is there an assumption of homogeneity?
Race and discrimination are both included in relation to communities of interest groups experience of health inequalities. This is the first report to acknowledge that this is relevant. However **BME communities** are being seen as a 'community of interest group' and not as many different groups. Evaluation of outcomes as a result of the JHIP is to include gathering qualitative data and not a reliance on quantitative data which is generally relied upon as sole indicators of progress. It may be that this will provide opportunities to demonstrate that there are specific differences between different **BME groups.**

Where BME communities are expressly mentioned, what are the proposals for engaging them in the decision-making process?
There are no specific **BME** groups, or FRAE Fife, listed as part of the lead task group and community partnership groups, although Dr Patel has since been included in discussions. There is a lack of information on how the actions in relation to **BME communities** are to be implemented. This illustrates the central challenge in relation to delivering real changes for **BME communities.** There is a gap between 'knowing and doing', between 'policy and action'.

Balanced Scorecard 2006/7

With what population is it concerned?
The section on health inequalities covered the following areas:

- Implementation of a Fife-Wide Tobacco plan
- Tackling inequality ratios by health improvement measures and supports i.e. smoking, dental cares, obesity, exercise, etc.
- Implementation of Sexual Health Strategy Action Plan.
- Increasing Breastfeeding rates.
- Delivering targets set out in JHIP.

All of the above were said to the meet targets set or national performance guidelines.

What BME demographic data underpins this?
None. There is no quantitative or qualitative data on **BME** in relation to these action areas, and it is therefore not possible to know if there has been any impact on their experiences of health inequalities in relation to planned outcomes.

Health Needs assessments of BME communities in Fife

This is part of the Race Equality Action Plan of NHS Fife for 2004 -2005. Under Community Development the plan states:
"Main aims are to carry out needs assessment for each community and identify key issues which communities wish to see addressed. NHS Fife staff will go out to visit communities in their own settings…"
This has not been done so far.

Overview of research into health needs of **BME communities** in Fife

2.2 There has been very little research that has specifically looked at or included members of the **BME communities** in Fife. The only research by Frae Fife, in partnership with the Public Health department, looked at the needs of **BME** minority elders.[38] The review is therefore dependent on national research findings as detailed below.

Diabetes
Research at a Scottish level has focused on diabetes, and the extent to which the needs of **BME** groups are actually met by the NHS Scotland:[39] The conclusions of the report are that:

> *"Improvement is needed in quality, completeness, and availability of minority ethnic group data for diabetes at a national level, particularly if NHS Primary Care Organisations are to be responsible for providing diabetes care as laid out in the Scottish Diabetes Framework."*

NHS Fife has an active working group on diabetes that includes representation from Frae Fife and a volunteer community worker. However a lack of data on ethnicity of those on the national register for diabetes across Scotland, and including Fife, continues to present challenges to taking forward joint initiatives. There is some 'opportunistic'

[38] The report on the event that publicised this research was not available
[39] Hamid R Baradaran, Joan Jamieson, Rafik Gardee, and Robin P Knill-Jones (2006), '*Scottish survey of diabetes services for minority ethnic groups'*. BMC Health Serv Res. 6: 130.

screening by the diabetes nurse specialist who attends some of the different **BME** groups. This is providing access to a limited number of people from these groups, but there are many groups like the Fife African Caribbean Association who, because they meet infrequently, are missing out in this screening service. This demonstrates the limitations of such an approach.

Mental health
Research has been undertaken into mental health services in Scotland. The report '*Equal Services'* concludes that:-

> *"Race equality from policy to operational practice - there is little evidence of race equality issues informing or influencing mental health services;*
> *Generic or mainstream approaches - the assessment demonstrated that both generic health and specific mental health approaches to policy development and service delivery are necessary so that people from black and minority ethnic groups feel confident that all their needs are being addressed."*

There appears to be a lack of investigation at a local level in Fife in relation to the mental health needs of the **BME** population. A Fife African Caribbean event in December 2005 identified concerns about isolation and depression within their community which were not being addressed.

There was a lack of tie up between research and policy development, as evidenced by a recent conference, held in Fife in March 2006, where specific equalities and interests groups highlighted in the summary report were "children and young people and people in their later years". Although issues relating to ethnic minorities may have been discussed at the conference, this was not reflected in the conference report or the presentations.

Conclusions - Policy Review and Review of NHS Fife Research

2.3 In conclusion the underlying factor precluding proactive inclusion of health care needs of **BME communities** in strategy and operational development, and the implementation of mainstream initiatives, is a lack of data, both quantitative and qualitative. There is also a lack of capacity within the current NHS structures to collect quantitative information, as well as researching qualitative data in support of specific initiatives that will address health inequalities of **BME communities** in Fife. As NHS Fife begins to carry out equality impact assessments on their new policies and on the design of services, lack of data and research may prove to be a substantial barrier. These assessments will cover all six strands and cross cutting issues. If there is no data or very limited data with reference to **BME communities** as a diverse group, there is the danger that judgments will be drawn from the impact assessment process based on subjective and personal experience and conjecture. This will lead to such assessments becoming mere paper-based processes and not real opportunities for reflective user-involvement in decision making that informs organisational development and culture. If qualitative research is to be commissioned it will be important to consider appropriate methodologies that will support engagement, consultation, community cohesion and capacity building.

Mapping of services geared to the needs of **BME communities** in Fife

2.4 Based on consultation with workers in various Community Health Partnerships, only one service designed and delivered by NHS Fife specifically for its **BME** populations was identified, namely the health advocacy project that is co-ordinated by Dr Daksha Patel, who is employed by NHS Fife but is working as part of the Frae Fife team.

***The* BME Community *Health Advocacy Project*:**
The project aims:

- to form a link between **BME communities** and NHS Fife;
- to speak on behalf of **BME communities** regarding health issues;
- to raise health awareness within the communities.

Through this project there has recently been delivery of screening services for diabetes and high blood pressure, and the provision of nutritional advice, at different community gatherings on an ad hoc basis,. This has been welcomed by different groups and also by NHS staff involved. The latter acknowledge the challenges to reaching through existing services **BME** clients who are not accessing health information or health prevention screenings.

The screenings involved the following groups:

- the African Caribbean community
- the Chinese community
- the Gypsy/ Traveller community
- the Polish community.

It is understood that these screenings did pick up individuals with specific conditions, who would benefit from further support and help from their GPs. This demonstrates the value of such outreach work. However there are several limitations of using this as the only means of providing targeted services for different **BME** groups such as:-

- the community events are not regular events or predictable as they are often ad hoc annual gatherings;
- the attendance of NHS staff to carry out screenings and provide advice is not regular and predictable either;
- those attending these community events are self-selected groups that will vary depending on the timing of events - lunch times / evenings / weekends etc. Age, gender, disability, sexual orientation, caring commitments, employment status, and access to transport may impact on attendance at such events;
- even if individuals attending are made aware of screening opportunities, there is the issue of lack of privacy which may impact on uptake.

2.5 This is a welcome initiative in terms of extending access to preventative health information and screening. However its scope is limited. There is an intention to develop this work further and to begin to develop a more strategic approach backed up by research in relation to particular conditions. Such an approach is intended to use research methodologies that support participation and develop the capacity of different communities to engage with mainstream services, and at the same time to provide opportunities for personal and skills development. However Dr Patel is employed currently part time on this project, while the resources required being able to deliver the intended developments would require full-time input and be part of a wider strategic approach to delivery of services to **BME communities.** .

Service Provision by the voluntary sector

2.6 There are many voluntary agencies working in Fife on specific health needs and interests. ***CVS Fife*** is a local intermediary organisation that seeks to promote social inclusion by supporting and strengthening the voluntary sector in Fife. It has several **BME** voluntary organisations as members. However it is aware that there may be a lack of capacity in terms of voluntary organisations that focus on specific health issues being inclusive and being seen as accessible by **BME communities.** .

2.7 ***Cancer Network Fife*** is an organisation that provides practical and emotional support, information and advice to anyone in Fife affected by the diagnosis of cancer. Cancer sufferers, their families, carers and friends can currently access their services in Ladybank, Anstruther Buckhaven and Dunfermline. The organisation is aware that to date there have been no enquires from **BME communities.** They are looking to address this as part of their planned strategic development, focusing on building their capacity to be an inclusive organisation through partnership working. The model adopted may be of relevance to the targeting by the voluntary sector of other specific services to dispersed **BME communities.** .

2.8 ***Voluntary Health Scotland (VHS***) is the national network of voluntary health organisations, and currently has 307 members. There is no information on the extent to which VHS has been undertaking capacity building work to support their members in being inclusive and developing the capacity to meet the needs of **BME communities** who are referred or who seek services.

2.9 Access to voluntary bodies that support specific health needs is often through recommendation and referral from clinicians. It is not known to what extent clinicians are aware of some of the services of voluntary groups, or give out information on them as a matter of course in a form that is always accessible.

Conclusions - Review of Services

2.10 In conclusion, there is only one NHS Fife service targeted specifically at **BME communities.** There is a need for further research into the services of voluntary organisations supporting **BME communities** with specific health needs. It is not known to what extent these agencies are providing culturally competent services that are easily accessible to **BME communities,** and whether their services are over-stretched in terms of meeting their needs.

Views of different BME communities on health services

2.11 Perceptions of services were based on observations at various events or through reports prepared by support workers.

a) ***Fife African Caribbean Association*** (FACA) held an event in December 2005 where they ran a workshop on health and well being (see appendix 1). The main conclusions drawn by participants were:-

- The importance of health issues such as sickle cell anaemia, diabetes education, depression, disability, ethnic food and dietary requirements, physical exercise, drugs e.g. cigarettes & alcohol; and of social issues such as culture change, financial pressures, child care, social isolation, and educational needs of African/Caribbean children.

- Dissatisfaction with current services e.g. isolation by exclusion; failure to meet special needs e.g. asthma requires more understanding by services; costs involved; not enough information on specific illnesses; lack of information, language barriers; low take-up of services.
- Improvements proposed – promotion of information (website with African/ Caribbean issues addressed); listening services - designed with Africans in mind; action on policies for the benefit of the whole population; public sector resistance to change – lack of employment or career development among black workers, qualifications not recognised – requires a change in attitude; representation on main statutory committees
- Requests that NHS policymakers attend such events.

This workshop demonstrated:-

- The high level of interest in the subject of health and their willingness to participate and engage with the policy makers.
- The need expressed for more focused sources of information, either through FACA or through the mainstream services being more aware of the information that would be supportive and relevant.
- An awareness of the importance of socio-economic factors particularly employment and career development, and how they can impact on health and well being.
- A high level of self awareness as African / Caribbean people of the impact that isolation, exclusion and often limited employment and career opportunities are having.

b) ***The Polish Community***

A similar exercise was undertaken at the weekly Polish community meeting in Burntisland over a two week period, although on a more informal basis. Working with an official interpreter the questions were translated into Polish, ensuring questions were meaningful in terms of concepts of health and well being. The responses given by the group were generally very similar to FACA with the general view that health was important so they could work.

The area that almost all expressed a need for improvement was access to dentists. The interpreter and co-organizer of these weekly events explained relevant cultural differences in consideration of views, and the need to build an understanding among new Polish and other East Europeans of the NHS health services and how they work. The concept of preventative healthcare is not one people arriving from East Europe may be familiar with. They have an expectation of accessing services when a need arises and action is required. This was reflected in the discussion on community dentistry services. The dentists arriving from East Europe have previously worked on the clinical basis that action is required to solve a particular problem, and they are less familiar with the role of the dentist as a provider of preventative treatment and education. Additionally there was an expectation of making a payment or providing gifts to those who deliver services in Eastern Europe, and there is perhaps some confusion as to how 'free at the point of use' works. This reflected the views of a group of Polish people living in Fife who are happy with the service they have received, other than in relation to their dental health. However it did highlight the need to build understanding and provide information on the way services operate in Scotland and what services are available to support their health and well being in the longer term.

c) ***Gypsy/travellers*** were another group that REACH wished to consult with but were unable to do so. However the FRAE Fife link worker reported that the 'hand held record research programme' has not been particularly successful in terms of changing the experiences of travellers in contact with the project. There is a general view that they are generally happy with the services that they currently access. And Dr Patel is currently working with this group to provide screening and information on a range of conditions. However decreased opportunities to work as agricultural workers has had a major impact on their well being because their annual income has decreased as well as other circumstances.

Views of NHS staff on engagement of **BME communities** in health service delivery

2.12 Fife Partnership[40] has adopted the National Standards for Community Engagement.

> *"Community Engagement is at the heart of community planning and we have a commitment to make sure that people and communities are in regular dialogue with all partners"*[41]

A number of NHS staff reported that engagement with **BME communities** was challenging, in terms of accessing a range of voices. In the last series of meetings of the Health and Well being Forums, of which there are three across Fife, no **BME communities** attended the public events. However this may be addressed now as NHS Fife is currently working with the National Resource Centre for Ethnic Minority Health (NRCEMH) on the Checking for Change pilot.

Conclusions – Review of views of service users and serve providers

2.13 The review highlighted a range of different views and needs among **BME** community groups, and a failure to engage these views in the Health and Well being Forums. There may be a danger of umbrella organisations that co-ordinate **BME** groups are seen as the voice for all communities - in the case of Fife this would be FRAE Fife. Often **BME communities** are seen as one homogenous group of 'others'. The impact of this is that 'real differences' are missed in equality impact assessments and that equality of opportunity is denied to all.

Mapping of Cultural Diversity Training delivered by NHS Fife

2.14 Cultural Diversity Training is taken to mean[42]: "knowledge and awareness building opportunity that may include the following:

- The diversity within **BME** communities, in terms of race, religion/faith, culture, language and country of origin, ethnicity, generation and migration timelines; it will support the development of understanding that all these are multi-factoral and not single issues, and should include mixed races.
- The health needs of **BME communities,** and specific determinants of health pertinent to **BME communities** as evidenced by research.
- The effective ways to engage with **BME** communities based on experience and research.
- The sensitivity issues within **BME communities.**.

[40] Fife Partnership is made up of Fife Council, Fife Constabulary, NHS Fife, Scottish Enterprise Fife, CVS Fife, Communities Scotland, Fife's Further and Higher Education Sector.
[41] Cllr Anne McGovern, Chair of Fife Partnership.
[42] As developed by REACH

- Highlight current legislation i.e. Race Relations Amendment Act (2000) and relevance to work.
- Highlight current government policy and Health Board policy in addressing health inequalities.

The intended outcomes of the Cultural Diversity Training are as follows. It will help individuals and their organisations to:-

- consider the health needs of **BME communities;**
- engage effectively with **BME communities;**
- be able to design services which are culturally and religiously sensitive towards their needs;
- to design services and interventions that will meet the standards set out by the Race Relations Amendment Act (2000).

2.15 In addition to legal requirements, various published reports highlight the need for health professionals to be informed of cultural diversity and race equality in the context of health inequalities.

> "*It is my belief that the medical profession and the wider health service still harbours and tolerates racism. This must change"*[43]
>
> *"In an increasingly diverse society it is essential that health professionals be equipped to respond appropriately and effectively. Underscoring this requirement is knowing about inequalities in health, access to health care, and quality of care experienced by diverse patient populations."*[44]
>
> *"Improved responsiveness to the health beliefs and practices and cultural needs of patients is clearly required to provide equitable access to health care for diverse populations. Such provision should also recognise that the provider and the ethnic minority patient each bring their own individual learned patterns of language and culture to the health care experience."*[45]
>
> *"This study indicates that cultural health care practices should be improved and staff attitudes changed by the delivery and uptake of effective and appropriate training, and as part of this effort community participation by minority ethnic groups should be encouraged to assist in identifying their specific needs for targeted health services and related information."*[46]

2.16 The challenge for the NHS is to ensure its workforce is competent to fulfil its duties and has the knowledge and understanding of cultural diversity and race equality. This requires a strategic approach over a period of time to raise standards of skills in the design and delivery of services. There is an inherent danger in the legislative demand for all NHS staff to receive training in cultural diversity and race equality that the NHS goes down a compliance approach, where one course is seen to fit all staff, and management is solely interested in quantitative data on numbers trained. The level and

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[43] Extract from a foreword written by Sir Liam Donaldson, Chief Medical Officer, Department of Health, Whitehall London. Raj Bhopal: Ethnicity, race, and health in multicultural societies. (2007) Oxford University Press.

[44] Valuing Diversity, 2nd Edition, edited by Joe Kai MD FRCGP, Professor of Primary Care, School of Community Health Science, Graduate Entry Medical School, University of Nottingham, Royal College of General Practitioners (2006).

[45] Szczepura A.: Access to health care for ethnic minority populations: Postgrad.Med J.2005;81;141 -147. (Report on Race Equality Assessments of Mental Health in NHS Boards : Equal Services?)

[46] Hamid R Baradaran, Joan Jamieson, Rafik Gardee, and Robin P Knill-Jones: Scottish survey of diabetes services for minority ethnic groups: BMC Health Serv Res. 2006; 6: 130.

type of training required by individuals to facilitate the appropriate development of their knowledge and skills in cultural diversity and race equality will vary depending on the nature of their duties and their responsibilities in the work place.

"*Equal Services*"[47] is an example of a report which makes specific recommendations on cultural diversity training in relation to mental health, namely:

- the development and delivery of training on race equality and cultural awareness for staff working in mental health, to be cascaded down the organisation;
- and secondly, a course developed to provide information about different concepts of mental health and illness, how these are presented in different cultures.

Review of Cultural Diversity and Race Equality Training in NHS Fife

2.17 ***Who is operationally responsible for race equality and the implementation of actions that support the NHS meeting its general duties?***

The Dunfermline and West CHP General Manager, has responsibility for reporting to the Health Board on Equalities, and demonstrates strong leadership and support for equalities work - for the work of the part-time race equality lead officer (two-days a week; an officer responsible for disability equality; and the appointment of an officer for gender equality later in the year. In comparison Fife Council, a key partner in the Fife Partnership, has one officer responsible for all equalities across the Council.

2.18 ***What training is provided a*t an organisational level?**

There has been some race equality training provided using the Jane Elliot workshop and video as a vehicle for learning. However this was a stand alone half day programme delivered in partnership with Fife Council.

There has been 'general equalities' training delivered at a corporate level:

- 500 managers from across the organisation, including primary and community care – ½ day training on diversity and equality;
- NHS Fife Board training organised by the Scottish Executive - general equalities and diversity training and not specifically race;
- Diversity and equality training within the induction programme for new staff plus a handout to support this information - 15 min slot;
- Statutory training for all staff every 3 years is planned - includes equality and diversity training in NHS Fife learning centre covering all 6 strands through software programmes.

> *"If it is only bad people who are prejudiced, that would not have such a strong effect. Most people would not wish to imitate them, and so such prejudices would not have much effect, except in exceptional times. It is the prejudices of good people that are so dangerous."*[47]

[47] commissioned in 2004 by the NCREMH

Training is planned for specific officers as follows:

- 10 trainers to be trained to cascade training -1 day training on diversity and equality;
- 25 staff to attend the police course on introducing diversity and equality – 2.5 days;
- Impact assessment training - ½ day training x 20 sessions for groups of 20 staff.

2.19 In conclusion, all the courses are general equalities courses. None focus specifically on race equality. And they are mostly very short courses. The content of training on offer appears not to include the following:

- demographics of **BME** populations in Fife; monitoring and data collection
- ethnicity and health, understanding culture and cultural difference, health in a cultural context, and its implications in Fife
- race awareness & understanding racial discrimination, promoting race equality in relation to health services, the language of equality, race and health care, understanding ethnicity
- cross-cultural communication issues, engaging with communities

2.20 The following section summarises the training on offer to specific primary health care staff.

a) **GPs** are required to have personal development plans. An advisor for GP development plans reported that there are no specific courses accredited for on going professional development that relate to race equality and cultural competency or to the broader topic of health inequalities and their determinants. In the event that such a course did become available it was felt unlikely that many GPs would prioritise this in their studies. However as more recently qualified GPs join practices it is hoped that there will be a building of capacity, as the subject of cultural competency and the different dynamics of it are increasingly included in the undergraduate curriculum.[48]

b) **Pharmacists.** There has been no training specifically for pharmacists in race equality and cultural awareness, and there are currently no continuing professional development (CPD) courses that address these issues. Existing CPD courses available from NHS Education for Scotland (NES) may contain integrated information in the curriculum that reference race equality, ethnicity, and cultural competency. However in the "*Flavours of Pharmaceutical Public Health*", one of the newer courses, the topic ethnicity or any reference to race equality was not included. Gender is covered, so it may be that cultural competence and ethnicity is considered under this heading. In conclusion, there appears to be no specific training for community pharmacists. The question to be addressed is whether there are contractual reasons as to why such training has not been considered as part of the procurement of NHS services. As the role of pharmacists increases, as part of the primary care team involved in public health initiatives, this needs to be addressed.

c) **Dentists.** The training offered to staff employed in community dentistry is the half-day on diversity. There is no training in race equality and cultural competency. The position of dentists is perhaps complicated by their contractual relationship with the NHS and the current way in which dentistry services are delivered.

[48] Valuing Diversity, Chapter 3 : 2nd edition.edited by Professor Kai.

2.21 ***Other specific primary care services***

- There does not appear to have been any joint training in race equality for both clinical and administrative staff within primary care.
- There has been no training provided to Marie Curie nurses. Taking into account the lack of uptake of voluntary sector cancer services, as noted by Cancer Network Fife, this may be an area where cultural competency and the provision of equality of opportunity to services, may be challenging for cancer support services.

2.22 In conclusion there has been limited race equality and cultural diversity training provided to NHS Fife employees. The training provided is in the main generic equality training:

- training for managers is on general equality and diversity issues;
- the proposed two and half day training course for a limited number of primary care staff will cover equality and diversity, but not specifically race equality;
- doctors, dentists and pharmacists, do not currently have continued professional development courses that cover duties under race equality legislation, or of health needs and health inequalities of **BME communities,** and if such courses did exist it's felt that this would be optional and not mandatory.

SECTION THREE

RECOMMENDATIONS AND PROPOSED ACTION PLAN

3.1 Area-Specific Research Agenda

The lack of quantitative public health data on **BME communities** in Fife plus qualitative data on health concerns will require a comprehensive and strategic approach to identifying and sourcing public health data and commissioning research to identify specific health needs of different sections of the **BME communities** in Fife, taking into account data on national prevalence rates and specific health risks.

REACH will contribute to this through:

- publication of a guide for NHS staff on key academic research on health inequalities experienced by members of diverse **BME communities.** .
- support for the application of participatory action research methodologies which build and support social and community participation by members of **BME communities** ..
- Advice on the development of performance measures for assessing the impact of operational plans in terms of addressing access to services by **BME communities.**

3.2 The Design of Community Health Prevention Services for BME communities.

The Joint Health Improvement Planning process of NHS Fife provides an opportunity to explore how community health prevention services might be developed and promoted among **BME communities** in Fife as part of mainstream delivery of services e.g. in relation to HIV and Aids, mental health problems, diabetes, coronary heart disease, cancer etc.

REACH has through its success in the development of a community health clinic in Glasgow identified core elements to health preventive services delivered to BME communities in community settings, providing the types of services that meet a broad range of health needs. It is proposed that this model, developed by REACH, is piloted in Fife by NHS Fife public health department in conjunction with local **BME community** organisations.

This pilot will also act as a resource to voluntary agencies in promoting provision by them of accessible services which meet the following equality criteria: - equal *access via appropriate information; access to services that are relevant, timely and sensitive to the person's needs; and being able to use the service with ease and having confidence that you will be treated with respect."*[49]

3.3 The Planning and Delivery of a Cultural-Diversity Training

NHS Fife is keen to meet its duties as defined in legislation and NHS Scotland guidance. However the generic programme of training in equalities issues is not sufficient to raise awareness of employees in terms of the following:

- legislative duties and service standards in relation to **BME communities.**
- specific health needs and causes of health inequalities

[49] Atkinson M, Clark M, D Clay, et al. Systematic review of ethnicity and health service access for London. Conventry:Centre for Health Services Studies, University of Warwick.

The recommended emphasis is not so much on compliance but instead raising awareness of the underlying rationale for legislative requirements and the design of services which will meet performance standards in relation to different sections of the **BME** population.

Future Direction

3.4 In terms of future direction of The National Project the following is proposed:

- In the next phase REACH in partnership with BEMIS will begin to work with NHS Highland.
- As part of this work consideration will be given to the impact that the strategy to address racial inequalities has had on the level and type of activities, and the rate of capacity building within Highland's public health and primary care services in terms of addressing health inequalities experienced by BME communities in the Highland area.
- REACH will also consider the benefits to primary care of the Culture Diversity Training offered by NHS Highland and will explore evidence that health care professionals as well as support and administrative staff are accessing this resource.

APPENDIX ONE

Aims and Objectives of BME National Community Health Development Project

Aim 1: '**Establishing the evidence of *racial inequality and disadvantage' in relation to health service delivery to the BME community***

- **Objective 1**: To carry out an **assessment** of the status of health delivery systems available to Black and Minority Ethnic (BME) communities within each of the targeted Health Board Area (HBA).

- **By:** Conducting: 1) a Literature Review of existing Health Board / Scottish Executive Health Department documents and reports, relevant to the Health Board, CHP documents 2) A review of existing research projects currently documented as taking place within the Health Board and those completed in the last five years, that specifically review health needs of black and minority ethnic people. 3) a Mapping Exercise on BME Health Services, and 4) a Mapping Exercise on Cultural Diversity Training for each HBA

Aim 2: *'Improving the provision of services and support to communities'* in relation to health service delivery to the BME community

- **Objective 2**: To complete an **analysis** of the findings of the HBA assessment and offer potential solutions

- **By:** Completing a report for each HB highlighting: 1) the state of health services available to the local BME community, 2) research gaps that exist with regards to health-related studies of the local BME community, and 3) the needs exist around cultural diversity training for health care professional providing services to the local BME community.

Aim 3: *'Driving up public sector performance on race equality and improving access to and benefit from public services'* in relation to health service delivery to the BME community

- **Objective:** To offer a comprehensive **action** package to each Health Board, based on the potential solutions identified in the above report

- **Potential solutions will include consideration of:** 1) an Area-Specific Research Agenda, 2) the design of a BME Community Health Preventative Service, and 3) a tailor-made Cultural Diversity Training Programme.

Aim 4: *'Developing the awareness and capacity of both majority and minority communities to engage with this agenda, to tackle racism and promote race equality'* (in relation to health service delivery to the BME community)

- **Objective**: To address race equality issues in relation to health and the BME communities aiming at raising awareness of all stake-holders and developing an action plan to be developed and delivered by REACH and the HBA's.

- **By:** Delivering a national **conference** which will include addressing race equality and BME health in rural areas

Bibliography

The Future of Multi – Ethnic Britain: The Parekh Report : The Runnymeade Trust 2002.

Ethnicity, Health and Primary Care, edited by Joe Kai MD FRCGP, Oxford University Press 2003.

Ethnicity, Class and Health, James Y Nazroo: Policy Studies Institute 2001

Valuing Diversity, 2nd edition, edited by Joe Kai MD FRCGP, Royal College of General Practioners.2006.

Ethnicity, Race, and Health in Multicultural Societies: Raj S Bhopal CBE, DSc(hon),MD, MBChB, BSc(hons), MPH,FFPH,FRCP(E). Oxford University Press 2007.

The Impact of Inequality: How to make sick societies healthier : Richard G Wilkinson. Routledge 2005

Identity: edited by Paul du Gay, Jessica Evans and Peter Redman. Sage 2003

Critical Race Theory, edited by Delgado and Stefanic.Temple Press 2000

Legislation

Race Relations Act 1976 and as amended by the Race Relations Amendment Act 2000.

Commission for Racial Equality Code of Practice on the Duty to Promote Race Equality in Scotland.

Websites

Scottish Executive : www.scotland.gov.uk

Commission for Racial Equality
www.cre.gov.uk

NHS Health Scotland, Scotland's Health Improvement Agency:
http://www.healthscotland.com/

The National Resource Centre for Ethnic Minority Health:
http://www.nrcemh.nhsscotland.com/

Black Health Agency:
http://www.blackhealthagency.org.uk/index.php/Section10.html

Centre for Research on Minority Health: http://www.mdanderson.org/departments/crmh/

NHS National Library for Health: Ethnicity and Health Specialist Library
http://www.library.nhs.uk/ethnicity/

Centre for Ethnicity & Health & Institute for Philosophy, Diversity & Mental Health
http://www.uclan.ac.uk/facs/health/ethnicity/index.htm

Healthcare Needs Assessments : The epidemiologically based needs assessments reviews.
http://www.hcna.bham.ac.uk/index.htm

British Medical Journal
www.bmj.com

Ethnic Minority Employment Taskforce
http://www.emetaskforce.gov.uk/index.asp

BBC website: articles
http://news.bbc.co.uk/1/hi/scotland/6498853.stm

COSLA: Strategic Migration Partnership:
Demographic Change in Scotland:
http://www.asylumscotland.org.uk/asylumstatistics.php

Equality in Care: NHS Health Scotland:
http://www.elib.scot.nhs.uk/portal/pfpi/pages/index.aspx?referer=AAS&un=nousername

Reports

Analysis of Ethnicity in the 2001 Census, Office of Chief Statistician February 2004. Summary report. Scottish Executive.
Health and Ethnicity, Indicators of the Public Health in English Regions: Association of Public Health Observatories.2005. www.apho.org.uk

Access to Healthcare and Minority Ethnic Groups: Kings Fund, briefing document February 2006.

Black and Minority Ethnic Elders' in the UK:Health and Social Care Research Findings,PRIAE Policy Research Institute on Ageing and Ethnicity 2005.ISBN 09537642-4-9 Published by PRIAE sponsored by the Department of Health

Inequalities in Health. Report of the measuring inequalities in Health Working Group November 2003

Audit of Research on Minority Ethnic Issues from a " Race " Perspective: Netto et al. Social Inclusion Research Programme. Research Findings No.4

Scottish survey of diabetes services for minority ethnic groups, Hamid R Baradaran, Joan Jamieson, Rafik Gardee, and Robin P Knill-Jones, accessed at http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1630428

Report on Race Equality Assessments of Mental Health in NHS Boards : Equal Services? National Resource Centre for Ethnic Minority Health.
Accessed at:
http://www.nrcemh.nhsscotland.com/pdfs/Equal%20services%20summary%20report.pdf

Improving Health in Scotland : The Challenge. NHS Health Scotland.

Fair Enough? Fair for All Progress Report: Analysis of Race Equality Schemes & Fair For All Action Plans. National Resource Centre For Ethnic Minority Health.

Fair for All Report : National Resource Centre for Ethnic Minority Health.

Scottish Gypsy Travellers Roundtable Report 2003, NHS Health Scotland.

Improving Government Service Delivery to Minority Ethnic Groups: Northern Ireland, Republic of Ireland, Scotland: edited by P.Watt and F. McGaughey. National Consultative Committee on Racism and Inter-culturalism. 2006.

Articles

Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Medical Care Research and Review: Med Care Res Rev. 2000;57 Suppl 1:181-217.

Should Muslims have faith based health services? Aziz Sheikh, professor of primary care research and development, Community Health Sciences, University of Edinburgh. BMJ 2007;334:74 (13 January), doi:10.1136/bmj.39072.347720.68 .

The Problem of Cultural Competency and How to Fix It.Kleinman A, Benson P (2006) Anthropology in the Clinic: PLoS Med 3(10): e294 . Accessed at:
doi:10.1371/journal.pmed.0030294

Parliamentary Note on Ethnicity and Health February 2007 England.

Scottish Executive Health Department: Our National Health Service, a plan for action, a plan for change accessed at:
http://www.scotland.gov.uk/Publications/2000/12/7770/File-1

Scottish Executive Health Department: Towards a healthier Scotland 1999.
http://www.scotland.gov.uk/library/documents-w7/tahs-00.htm

Economic Briefing for Fife: Analytical Services Division
Enterprise, Transport and Lifelong Learning Department
Scottish Executive

Black and Minority Ethnic Health in Greater Glasgow. A Comparative Report on the Health and Well Being of African and Caribbean, Chinese, Indian and Pakistani People with the General Population. Compiled by Derek Heim and Susan Mackaskill, 2006. NHS Health Scotland,

Ethnicity and Health in Scotland, Can we fill the information Gap? Bhopal data collection and CHD Health BME Retrocoding%20final%20report

The third Phase of ASH Scotland's Tobacco and inequalities project 2003 – 2006. Black and Minority Ethnic Briefing Paper.

Diabetes service provision: a qualitative study of the experiences and views of Pakistani and Indian patients with Type 2 diabetes: J. Lawton, N. Ahmad, L. Hanna, M. Douglas and N. Hallowell

Diabetic Medicine: Volume 23 Issue 9 Page 1003 - September 2006 doi:10.1111/j.1464-5491.2006.01922.x

Access to health care for ethnic minority populations: Professor A Szczepura, Division of Clinical Sciences, Warwick Medical School. Postgrad.Med.J.2005;81;141-147.

Diversity training for psychiatrists. Nisha Dogra & Khalid Karim. Advances in Psychiatric Treatment (2005);vol.11,159-167

Reduction of inequalities in health: assessing evidence-based tools: Peter Tugwell[1 et al] International Journal for Equity in Health2006:5:11

Toolkits

Communication Guidelines for the Introduction of Ethnic Monitoring in Health Boards in Scotland: NHS Health Scotland. Accessed at: http://www.isdscotland.org/isd/files/COMMUNICATIONS%20GUIDELINES.pdf

Ethnic Monitoring Toolkit : NHS Health Scotland.
Checking for Change: A building block approach to race equality in health : National Resource Centre for Ethnic Minority Health.

Peer Review Toolkit: National Resource Centre for Ethnic Minority Health

Equality Impact Assessment Toolkit : Accessed at :http://www.scotland.gov.uk/Publications/2005/02/20687/52421

Prevention 2010, Engagement and Concordance Evidence overview. A resource for Pilots, March 2006: Accessed at http://www.scotland.gov.uk/Topics/Health/health/Inequalities/Evidence