

# Race for Health

## Bradford City Teaching PCT

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### Profile

Fifty-three per cent black and ethnic minority population (50.2 per cent Asian) / 156,000 people covered / The area has high rates of ill-health and mortality, high structural unemployment, continuing problems with racial harassment, skills gaps and lower than national average income / Bradford Education scored 137th out of 150 LEAs / Young Asians in Bradford are underachieving.

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### Our BME population faces big issues ...

<b>Lifestyle</b>	To accept that health can be improved by changing personal lifestyles and developing lifestyles in relation to diet and physical activity, which facilitate healthy living and let go of traditional customs and practices.
<b>Challenging services</b>	It is important for BME communities to recognise existing health inequalities gaps and play an active role in questioning the provision of services. This will help to influence the future of primary care service development. By asking for what they need, BME communities can improve their health.
<b>Institutional change.</b>	There is an emphasis in Bradford on piecing together the full patient journey to build in culturally competent systems that tackle inequalities such as registering with a GP, lack of access to interpreting and where there is poor communication between patients and GPs. We want to ensure that this information is used to deliver services that match the religious, cultural and linguistic needs of patients.

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### Our workforce needs...

<b>To reflect the BME community</b>	25 per cent of the workforce is from ethnic minorities, and few are in senior positions. It is important to have a workforce with shared language and cultural understanding to help make our services more sensitive to cultural needs.
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## More opportunities

More opportunities are needed for professional development among ethnic minority staff to help recognise different needs in our population. If we do not have reflective front line staff able to communicate well, it presents a problem in terms of community understanding and health promotion.

## Varied entry points.

We need to raise the skill base in the ethnic minority community. To do this, we need to enable people to develop step by step through in-service training rather than necessarily through formal academic qualifications.

## Commissioning raises issues...

### Poor data

Due to the lack of detailed data and information about our local population, primary care organisations and commissioners are unable to channel resources or measure the impact of services, because of the lack of clarity about whom services are provided to.

### Culturally sensitive services

There is a need to develop robust systems and processes which collate accurate data and intelligence about our local communities and their needs. This information needs to be used meaningfully in the design and the delivery of culturally sensitive services.

## We're proud of...

### Our research study

This study is of the largest ethnic minority community in Bradford City PCT – people of Pakistani origin. It looks at how individuals progress on the care pathway. This qualitative study looks, for example, at dietetics, diabetes and podiatry, to identify barriers to care and highlight where changes are necessary.

### Consultations

We have held meetings and discussions with community and faith leaders to understand the cultural and religious needs of their communities. We are working to understand the potential barriers and obstacles that patients can experience during the care pathway and to highlight measures that have to be taken to modify provision of care to ensure that this is more culturally appropriate.

## Next steps...

We will appoint a Diabetes Outreach Worker to support health promotion and self-care management with south Asian patients. We will create a DVD for south Asian communities on healthy eating. We will create improved language services following a major mapping exercise.

### Programme Lead

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# Race for Health

## Bristol North PCT & Bristol South and West PCT

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### Profile

The most diverse place in the West Country / A long-established African-Caribbean, Pakistani, Indian and Chinese population / Also substantial, and more recent, African communities, particularly Somali, with growing numbers from eastern Europe / 8.2 per cent of Bristol's population is from black and minority ethnic communities.

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### Our BME population faces big issues...

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#### Mental health

In Bristol as elsewhere, people from BME communities are over-represented in the take-up of mental health services. We need to understand better why this is and to address the issues that allow this situation to persist.

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#### Access to services

There is a high concentration of asylum seekers and refugees with multiple, complex needs living within the inner city wards of Ashley, Easton and Laurence Hill. Although we have a number of excellent specialist services, it is a challenge to meet their health needs appropriately, developing good services that cater well for minority languages, cultural sensitivities, the mobility of the population and inter-community differences.

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#### Particular diseases

There are high levels of diabetes and coronary heart disease in BME communities, particularly among the south Asian population.

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### Our workforce needs...

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#### BME representation at senior levels

9.38 per cent of staff in the two PCTs are from BME communities compared with 8.2 per cent of the general population. These communities are over-represented in the lower pay scales but under-represented at senior levels. Locally, a BME staff group and mentoring scheme supports advancement of BME employees. These programmes supplement national policies.

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#### To use BME skills

This is particularly an issue with asylum seekers and refugees who come with health and social care skills that they cannot use adequately in the UK system because they qualified elsewhere. A course run by Further

Education colleges attempts to steer such people, who may lack language skills, into the right training so they can practise here.

## Commissioning raises issues...

### Commitment to race equality

We want to use our influence to ensure that service providers are committed to race equality. Commissioners can ask for evidence that providers have a race equality scheme, are adhering to race equality principles, are collecting and acting on ethnicity data.

### Capacity in the voluntary sector

There is a need to support BME organisations to build capacity as providers, so that it is possible to commission culturally sensitive services.

## We're proud of...

### Training staff in cultural competence

In partnership with other local NHS trusts, we recently trained front line and other staff in cultural competency. The training offered simple tools. For example, when dealing with an unfamiliar name, it advised staff to ask the person to spell the name and to take the time to write it down properly. The training showed that it is alright not to know certain things and offered simple ways to deal with not knowing.

### Care for asylum seekers

The Haven is a primary health care service dedicated to asylum seekers. Patients get lost in the system and need such culturally sensitive, accessible, centralised services that meet people's needs.

### Diabetes project

The South Asian Diabetes Facilitators' Project is funded by NICE as a pilot. The project employs two South Asian facilitators to work with the community. They explain how to avoid developing diabetes as well as how to improve health outcomes for those who have already developed the condition. An evaluation of project outcomes is expected to be completed in the summer of 2006.

### The Bristol Race Equality Health Partnership

Partnership between health service providers and BME representatives helps trusts work on race equality and gives BME communities a real opportunity to hold providers to account and to create change.

## Next steps...

To build on the community facilitator model piloted through the diabetes project to target services better, for example to promote smoking cessation and infant feeding in BME communities. A 12-week programme will train local recruits in health promotion techniques in the community. We are also using influence on providers to develop data for BME communities on waiting times for referrals and for elective treatments to monitor equity.

### Programme lead

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# Race for Health

## Central Manchester PCT

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### Profile

Thirty-one per cent black and ethnic minority population (9.8 per cent Pakistani; 4.5 per cent Black Caribbean; 3.3 per cent Black African; 2.2 per cent Indian; 2 per cent Bangladeshi; 1.8 per cent Chinese) / 192,740 people covered / The majority of the trust's population live in the city's most deprived wards, resulting in considerable health and economic disadvantages for these residents.

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### Our BME population faces big issues...

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#### Deprivation

The trust's ethnic minority population mostly live in areas of deprivation, where there is poor housing and unemployment. So their health and well-being faces multiple challenges.

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#### Poor information

The PCT, as elsewhere in the country, faces a shortage of data on the needs of the ethnic minority population at the level of general practices. GPs are now remunerated for collecting information on the ethnicity of new patients, but not on their existing list. So the trust has real problems knowing the details of local needs, even though national statistics indicate numerous health disadvantage issues for the ethnic minority population.

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#### Transience

Manchester has a rapidly changing population and the trust has to be mindful that our services are accessible and responsive to change.

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### Our workforce needs...

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#### Better representation

From the ethnic minority communities. Some 12 per cent of the trust's staff are from such communities, compared with 31 per cent of the population. A more reflective workforce would make services more sensitive – the ethnic minority population might also feel more able to access help.

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#### More local recruitment of minority staff

The trust is creative in encouraging BME people to take up positions working as practitioners. There is concern that people may not be coming forward because they do not have the relevant qualifications or because ethnic minority staff recruited in the 60s have regrets about their own experiences and so may not encourage their own children to apply.

## Training for ethnic minority staff

This issue is becoming more acute with the shift to patient-led commissioning. The reduction in NHS managers means that the opportunities for ethnic minority staff to advance could be reduced. The trust is working to ensure transparency in selection processes.

## Commissioning raises issues...

### Engaging general practice

In the race equality agenda. Elements of responsibility for commissioning are being devolved to general practice so the trust is working to make sure that already marginalised groups do not become even more isolated.

### Appropriate provision

We need, for example, to ensure that a patient, whose first language is not English, can communicate with a district nurse. Or a Muslim patient who attends an acute hospital can obtain halal food. Commissioners need to make sure that race equality considerations tackle such important details.

### Better quality data

We want to encourage GPs, who are busy people, to develop patient profiling and to use the information to inform commissioning decisions.

## We're proud of...

### The Speech and Language Service

Which is working to support children from bilingual or multilingual backgrounds. The goal is that, even if a child understands English, staff can also work in their mother tongue.

### The Pills and Spills project

Which delivers medicines with better labels – using ethnic minority languages to make it easier for elderly people to manage medication.

### Change in attitudes

A visible shift in behaviour and attitudes within the organisation towards the agenda of equality and diversity. If people are more aware of race issues, then they feel more comfortable challenging behaviour and questioning decisions the trust makes in helping the diverse population it supports.

## Next steps...

Build capacity around the whole equalities agenda. The three Manchester PCTs will shortly merge, offering an opportunity to assess what will be required not only in resourcing, but also in structuring race equalities work. In the reorganisation, we don't want to lose the progress already made.

To improve the knowledge of health needs at a local level. That will require working through practice-based commissioning, and supporting GPs, many of them highly skilled around diversity, in building up ethnicity data and using this knowledge to inform commissioning contracts.

Act upon data from Race Impact Assessments which are an excellent tool for supporting change. Where poor access to services has been identified, the PCT hopes to better target services at those in need.

### Programme Lead

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# Race for Health

## Ealing PCT

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### Profile

Southall, population 64,500, is focus of the Trust's Race for Health programme / Ethnic communities comprise 88 per cent of some Southall wards / Southall is one of England's most deprived areas / High death rates for some causes / Diabetes incidence is double for Black communities, three to four times for Asian communities.

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### Our BME population faces big issues...

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**High risk of diseases** Our BME population faces higher risks of certain diseases such as diabetes and coronary heart disease.

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**Access to services** For some BME groups there are challenges concerning their access to, for example, breast and cervical cancer screening (cultural and religious sensitivity may make communities harder to reach). There may also be issues of access to, for example, mental health services and services for older people. There are substantial numbers of refugees and asylum seekers within the PCT. For many, the health system is unfamiliar so they may have difficulty registering with a GP. Language can be a barrier to getting access to services: we have interpreting services to help out.

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**Migration** There are large numbers of migrants, who suffer higher incidences of certain infectious diseases, such as TB and HIV, reflecting incidence in their country of origin. The mobility of travellers can make it more difficult to assess, monitor and meet their health needs using conventional systems.

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### Our workforce needs...

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**Greater opportunity at senior levels** The profile of the workforce reflects the ethnic profile of the population. However, until recently, there has been a higher proportion of BME staff in the lower pay bands than in senior positions. There is an active BME staff network looking at training needs and tackling issues of bullying. We have developed a local Breaking Through programme, modelled on the national programme aimed at supporting the advancement of first line managers.

## Development of accreditation

People who qualify overseas often find that the costs of requalifying in the UK are too high. So the trust misses out on a clinical workforce reflecting the ethnicity of our community. We have done some awareness raising. We held a careers fair in Southall where we asked the Workforce Development Confederation to talk about requalification routes for nurses.

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## Commissioning raises issues...

### Accountability

We must ensure that the providers from which we commission are as committed to race equality as the PCT.

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### Primary care services

It is vital, in commissioning a patient-led NHS, that race equality is linked into local/practice-based commissioning. This can be difficult in areas of deprivation because those are often areas with the most single-handed practices which are less able to develop their commissioning role.

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### Integrating race equality

A major challenge is to link race equality schemes into all parts of PCT practice including commissioning. Staff need to be aware that every service should be assessed for its differential impact on different communities.

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## We're proud of...

### Local Breaking Through initiative

It has been important in raising the PCT's awareness of BME staff advancement.

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### CHD equity audit

We reviewed all aspects of CHD. The study showed intriguing patterns. In some areas where there is high mortality and morbidity from CHD, we found low levels of prescribing. The findings suggest that, in some cases, people are not getting the medication needed. Not all areas of mismatch between prescribing and morbidity were characterised by deprivation and a large BME population, but we need to put effort into these areas.

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### Refugee health advocates

We have developed these advocates to work in GP practices at the invitation of the GP. They help patients to understand health systems and how, for example, to contact the local authority about housing. We also offer counselling in non-English languages to refugees.

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## Next steps...

We will do more equity audits, possibly of diabetes care. We will take practical action to improve services. We will consolidate initiatives taken by the BME staff. We aim to make sure that race equality is embedded in practice-based commissioning and in the work of independent contractors.

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### Programme lead

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# Race for Health

## Eastern Leicester PCT

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### Profile

Fifty-two per cent black and ethnic minority population / Predominantly Asian (44 per cent) with black or black British the second largest minority (4 per cent) / Leicester has a population of 279,921 / The Indian population, many of whom fled east Africa in the 1960s and 1970s, is the largest outside London / In some wards, up to 75 per cent of people are Indian.

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### Our BME population faces big issues...

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<b>Engagement</b>	Surveys tell us that the community does not feel that it has real influence on the PCT yet, so a key challenge is to foster effective engagement.
<b>Empowerment</b>	The community does not feel empowered with relevant information and it does not feel it has the relevant networks to access services.
<b>Literacy and language</b>	We have a significant part of the population whose first language is not English. The majority of the BME population are Hindu Gujarati. There are much smaller pockets of Somali people plus African-Caribbean, Pakistani and Bangladeshi communities. Some of these groups face challenges with language.
<b>Community services</b>	People feel that there are a lack of community-based health services, especially for mental health and diabetes.

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### Our workforce needs...

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<b>Good understanding</b>	It is vital that our staff understand the implications of how race equality works and its impact on service delivery and improvement. We need greater cultural competence in meeting the diverse cultural, faith and ethnic needs of our diverse population. It is not always easy to achieve this at times given the diversity of our staff and of our client group.
<b>Career development</b>	BME staff want greater access to career development and training opportunities. They are often excluded from the informal staff networks. The majority are located at the lower levels of the organisation.

## More role models

There is a lack of BME role models in senior positions in the organisation. About 36 per cent of staff are from BME communities. At middle and senior management level there is reasonable BME presence. However, at the top level, there is only one BME assistant director.

## Commissioning raises issues...

### Voluntary sector capacity

Some BME voluntary groups feel they are unsupported and cannot bid for large commissioning contracts. The PCT needs to build their capacity to compete. Their services are vital in areas such as mental health where larger organisations struggle with issues of cultural competence.

### Procurement

We are working with our procurement colleagues to raise their awareness of the requirements of equalities legislation to achieve better outcomes for our BME communities.

### BME involvement

The thrust of policy development is towards commissioning a patient-led NHS using practice-based commissioning. But BME communities are insufficiently empowered to be effectively involved in this process.

## We're proud of...

### Black staff network

Establishing the black staff network and the external reference group, which engages with the local communities. This provides a mechanism whereby local BME community organisations can scrutinise our policies, procedures and services to make sure they are responsive to BME communities. The black staff network looks at training and development for black staff.

### Cervical screening

We have improved take-up among Somali women as part of a broader project to improve the take-up of screening across our population groups.

### Mosaic

Mosaic is a Department of Health pilot project promoting race equality in procurement. We will be training our procurement team in the requirements of race equality legislation. We have base line data on our existing suppliers, detailing, for example, their current ethnic makeup. We are working to ensure that tier 1 suppliers implement equalities legislation.

## Next steps...

We will introduce sustained work on mentoring and coaching our BME staff, building on a current pilot. We want to ensure that an effective internal structure exists within the PCT to performance manage equalities work, enabling the engagement of key stakeholders, including our local community and staff. A key priority is also to acquire robust ethnic monitoring data that will inform service improvement.

### Programme Lead

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# Race for Health

## Haringey Teaching PCT

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### Profile

Majority (55 per cent) from ethnic minorities / Including African-Caribbean, African, Bangladeshi, Pakistani, Indian / 166 languages spoken / 40 per cent of children have English as their mother tongue / 14 per cent don't speak English / 10 per cent are refugees or asylum seekers / Infant mortality 7.4 per 1,000 live births (national average 5.9) / Up to 14 per cent of babies have low birth weight.

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### Our BME population faces big issues...

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<b>Scale of diversity</b>	The mix of populations makes it hard to target services.
<b>Poverty and mobility</b>	The different ethnicities tend to be in the poorer districts. People may not stay long, making it hard to find them the right services.
<b>Tensions</b>	The large immigrant population brings drive and energy. However, longer-settled communities may feel at times that newer communities are in competition for scarce resources.
<b>Poor understanding</b>	We don't have a good breakdown of health indicators by particular ethnic communities. But we do know that the population in eastern Haringey have higher rates of admission to hospitals, die younger and face specific health challenges: HIV and TB in the African population, diabetes in the Turkish population and sickle cell disease in the African-Caribbean population.
<b>Conditions</b>	Higher rates of antenatal infection in mothers including Hepatitis B, HIV and syphilis, reflects the incidence of these diseases in their countries of origin.

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### Our workforce needs...

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<b>Help with language</b>	It's difficult to provide a full language service, when staff are in a hurry and may be unable to wait for translators or the language link service. We are focusing on telephone-based translation now.
<b>Cultural sensitivity</b>	A patient may come from one culture, a worker from another and each is operating in a host culture which is different again. Our staffing is relatively

representative – 45 per cent are from an ethnic minority. But with so many different countries of origin, it is hard to be culturally fluent for all patients.

### **Adaptability**

There can be sudden changes in the nature of the populations because of political change. Between 1991 and 2001, there was a 93 per cent increase in the African population.

## **Commissioning raises issues...**

### **Language and advocacy**

Trying to commission sufficient services to meet the communication needs of the local population is difficult because of the financial cost.

### **Providing particular services**

We need to commission in proportion to the morbidity of disorders that are particularly prevalent to certain communities, such as TB and HIV.

### **Leveraging GPs**

In the past, GP services have been designed as one-size-fits-all services, based on a national contract. How do we commission primary care suitable for our populations?

## **We're proud of...**

### **Reviews**

We have reviewed language and advocacy services. We have also done an equity audit of our health visiting service. We are looking at the level of needs and redistributing services according to demand.

### **Supporting BME staff**

We've done a lot of work trying to develop ethnic minority staff programmes. Haringey Aspiring Together – HAT – supports the career advancement of ethnic minority staff. The BEL programme – a black and ethnic minority leadership programme – is a key support.

### **Active Living programmes**

Health for Haringey, partly funded by the Big Lottery Fund, pays community-based organisations to run exercise sessions for their community. These active living programmes are reaching large numbers of people in BEM communities.

## **Next steps...**

We are analysing our ethnic monitoring data better so that we understand the sickness patterns among our ethnic minority populations.

We are developing a Turkish Language-Based Expert Patient Programme so that we ensure greater abilities of our communities to self-care. This complements our existing Greek-based programme. We will also be developing a Greek language-based cardiac rehabilitation programme. We would like to start using Race Equalities Impact Assessment better to drive forward improvements in our service delivery.

### **Programme Lead**

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# Race for Health

## Lambeth PCT

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### Profile

Lambeth has 345,000 people registered with 53 general practices / The total BME population is 37.7% compared with 5.9% for England & Wales, with more than 150 languages spoken / Largest ethnic group is Black Caribbean (13.5%) followed by Black African (9.7% ) and Black Other (3.8%) / Newer residents include high proportions of Portuguese and Latin American immigrants.

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### Our BME population faces big issues...

**Smoking prevalence** About 35 per cent of adults smoke in Lambeth, compared with 26 per cent nationally. An equity audit profile showed that fewer black smokers used stop smoking services and, when they did, fewer were likely to quit.

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**Obesity** National health survey data shows that obesity prevalence is higher among certain ethnic groups including black Caribbean and Pakistani women. Obesity is a risk factor for heart disease and cancer. Both heart disease and cancer are the biggest causes of premature deaths in Lambeth.

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**Sexual health** Between 1996 and 2003, the prevalence of HIV infection more than doubled in the area. In 2003, more than 25 per cent of Lambeth residents with HIV were black Africans. Between 2002 and 2003, 95 per cent of HIV infections in pregnant women in south-east London were identified before delivery, a particular benefit to the black African community.

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**Teenage motherhood** Some 35 per cent of teenage mothers are black Caribbean or of Mixed (black Caribbean/white) origin, whereas only 23 per cent of young women aged 14-19 are of these ethnicities.

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**Tuberculosis** In 2003 more than half those newly diagnosed with TB were black Africans.

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### Our workforce needs...

**Cultural awareness** The trust is offering staff a one-day Cultural Competency course which aims to provide them with a greater understanding of different cultural groups.

## **BME management and leadership**

About 40 per cent of staff are from BME backgrounds, which is broadly representative of the local community. But there is a higher percentage of staff from BME groups in lower pay bands. The majority of middle/senior managers are white. The PCT aims to set targets for improving the representation of non-white staff across all grades within the PCT.

## **Local recruitment**

Drawn more from the local population. The PCT is currently using NHS Jobs as the main recruitment source although job packs are sent to people contacting the PCT directly. The challenge is to improve local recruitment.

## **Commissioning raises issues...**

### **Awareness of equalities issues**

We want to tackle this across all the PCT's functions, as a commissioner, provider of services and employer. The PCT has a Health Inequalities and Diversity Steering Group, chaired by a Non-Executive Director, which has responsibility for setting strategic direction for health inequalities and diversity across the PCT, to ensure one approach for each of its key roles.

## **We're proud of...**

### **Anti-bullying actions**

The PCT has trained 10 Bullying and Harassment Support Workers

### **New thinking**

Lambeth's public health report has developed important assessment of issues of health equity.

### **Improved priorities**

The PCT is starting to implement the choosing of health priorities based on equity considerations.

## **Next steps...**

### **Training**

Mandatory training for all staff is to be introduced which will include training for all in equality and diversity issues.

### **New work policy framework**

The policies, based on respect and dignity at work, will cover Equality and Diversity in Employment, Anti-Bullying and Harassment and a Staff Code of Conduct. The policies will set out clear standards of behaviour which are expected from all staff and will also be supported by a very clear message from the PCT Board and Senior Management Team that all staff must be treated with dignity and respect.

### **Improved data collection**

The PCT expects the Trust to adopt the Department of Health Practical Guide to Ethnic Monitoring to capture information on ethnic group, religion, language and diet.

## **Programme Lead**

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# Race for Health

## Learning from each other

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Sue Charteris is the director of Shared Intelligence, which is Race for Health's learning programme advisor. She explains how the programme pioneers new thinking and practice in tackling health inequalities based on ethnicity.

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### PCTs have helped each other...

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**A key aspect of the Race for Health programme is the practical commitment to learn together and from one another.**

The way learning takes place has changed as the programme has developed. We began with "open house sessions" or appreciation visits, large scale events in which a Trust demonstrated what it was trying to achieve. From there we have moved to a short and intensive "peer review" model. A team of six to seven peers reviews a particular aspect of a Trust's work towards race equality for which it needs focused advice and help.

The way we learn from one another has evolved as the programme has grown in confidence. However, some aspects have remained consistent throughout. When the Race for Health Primary Care Trusts come together there is a spirit of trust and openness. This combines with empathetic questioning from colleagues facing similar challenges in their home PCTs.

What is more, the appreciation visits and peer reviews are beginning to highlight some striking elements that seem essential features of good practice.

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### Key features of Race for Health PCTs...

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**While the context, demographics and particular circumstances of the Race for Health PCTs are different, they all, in different ways, demonstrate a number of features:**

- 1 Clear and expressed commitment from the Chair, Chief Executive and PEC Chair.
- 1 A drive to dignity and respect for all; staff, patients, communities and partners.
- 1 A commitment to making ethnic monitoring work by overcoming practical obstacles.
- 1 An understanding of their communities and changing needs. They are listening to the voices of patients and developing an approach to community involvement that is becoming second nature.
- 1 Working with communities, beginning to use their skills and knowledge to reshape services.
- 1 Beginning to influence the race equality agenda beyond the PCT – with partners in GP practices, Acute Trusts and local authorities.
- 1 Increasing use of evidence to make the right judgements on the factors behind the early onset of

diseases in some communities. They are tackling potential obstacles to the take-up of services and beginning to design customised and relevant services for those communities.

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## Inspiring examples of work...

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**None of the PCTs in Race for Health would claim to have all these ingredients in all aspects of their practice. However, through the determination, ability and persistence of key individuals they are making real progress. Some inspiring examples of this are:**

- 1 Practitioner GPs transforming the way they respond to their communities, and working with the PCT to influence other GP practices to do the same.
  - 1 The use of expert patient and community champions to work within communities.
  - 1 Much greater understanding of the need for culturally sensitive service provision. PCTs are working with local communities to design such services – whether it be diabetes prevention programmes in South Asian communities or work to transform mental health services for the African Caribbean community.
  - 1 The use of creative incentives and levers to encourage change to happen, through, for example, smarter specifying of requirements to GP practices.
  - 1 These initiatives are generating a stronger evidence base of community need and increasing the reliability of monitoring data.
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## We need to consolidate learning...

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**Challenges remain and there is scope for improvement. Important steps would be:**

- 1 Building confident commissioning relationships with providers, especially Mental Health Trusts.
- 1 Building on the BME staff networks and BME health forums that many of the Trusts have in place, to maximise their influence within the Trust. It will be important to develop stronger two-way feedback on service redesign and culturally sensitive commissioning.
- 1 Working out, within the reconfiguration of PCTs, where and how dedicated resources are needed to meet particular needs, for example, for TB patients and those suffering from sickle cell.
- 1 Working together to assess the newly emergent needs of communities in transition, tackling the data deficit and improving the monitoring of BME health outcomes.

**So far then, we can demonstrate innovative and positive work in many aspects of all the PCTs in the Race for Health programme. The challenge now is to embed that change in a more systematic way. The ingredients are in place for this to happen.**

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**Peer review teams** comprise six or seven peers from across the Race for Health community. This would include a Chair, Chief Executive, a non-Executive Director, and other practitioners. There would also be commissioning colleagues and representatives from public health and community development. They would be accompanied by the Trust's thinking partner and a representative from the Department of Health's Equality and Human Rights team. The terms of reference are agreed with the host PCT and background papers are assembled. The participants spend 1.5 days on-site meeting key stakeholders, and give critical and constructive feedback on what impressed them. They suggest next steps, and a full report is posted on the Race for Health Web site within a month. These peer reviews are forming the baseline for evaluation of the programme.



# Race for Health

## Shropshire County PCT

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### Profile

Affluent, rural county with a population of 287,900 / Most live in market towns / The proportion from BME groups has risen from 0.7 per cent in 1991 to 1.2 per cent (3,500 people) in 2001 but well below national average (8.7 per cent) / Largest group are Chinese, followed by Indian, then White and Black Caribbean / Small BME population dispersed across the county, posing a challenge to the development of a BME-specific service provision – and to ensuring that race equality stays on the agenda.

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### Our BME population faces big issues...

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<b>Size</b>	This is a small BME community so there are no individual services geared to meeting any specific service needs that they may have.
<b>Fragmentation</b>	The rural nature and size of county means that BME communities are scattered and have little contact with each other. The distance between services and potential users is a barrier to access.
<b>Low priority</b>	Issues of race discrimination occur infrequently and so are not always considered to be a significant issue to the local media. The fact that needs are not being prioritised is compounded by the reluctance of the community to seek support. Victims of racial harassment and racially aggravated crime do not wish to seek help and draw attention to themselves, according to a recent report by the Community Council.
<b>Inadequate language support</b>	This is a frequently cited barrier to accessing services. It includes the ability to understand the processes of public sector providers – schools and health care in particular.

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### Our workforce needs...

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<b>Greater awareness</b>	About small BME communities in its areas. We hope that our survey of the Chinese community will help with this goal.
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**More knowledge** Of race equality issues so that it is better placed both to serve the community and to recognise issues in workforce development.

**More understanding** In our PCT 2.5 per cent of the staff group are from the BME communities. So they are sometimes seen to be over-representative of the local BME populations.

## Commissioning raises issues...

**Targeting** It is difficult to commission services that specifically treat, care and support these small communities.

**Poor awareness** There is a lack of awareness of the experiences of this community because there has been little engagement with these small scattered communities.

**Lack of information** Primary care is unable to provide much information on people's access to health services. Hopefully, we will begin to address this issue now that the recording of ethnicity is part of the GP contract.

## We're proud of...

**Race for Health** We're glad we joined the programme and raised the profile of local race equality issues and demonstrated nationally that race equality is not just an urban issue.

**New initiatives** We have commissioned the national Chinese Healthy Living Centre to survey the 1,000-strong ethnic Chinese community in Shropshire to assess their health needs and experiences of local health services and help to promote their engagement with local public services.

**New staff** We have appointed a race equality lead and provided a focus for this work.

## Next steps...

**Improve services** Develop the partnership arrangements with the local authorities in Shropshire to deliver co-ordinated improved services to the local BME communities. It is not enough to simply survey their needs.

**Primary care** Assess the BME communities' access to primary care in Shropshire. There are questions about how language can be a barrier and about problems booking appointments with GPs.

**Support initiatives** Prime a small number of initiatives to provide better access to health services, including recreation services and self-help materials.

**Programme Lead** **John Short**, Director of Mental Health and Learning Disability  
Services **01743 492043** or **[john.short@shropshirepct.nhs.uk](mailto:john.short@shropshirepct.nhs.uk)**

# Race for Health

## Slough PCT

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### Profile

Thirty-seven per cent ethnic minority population; mainly Indian and Pakistani / New communities arriving from Africa and Eastern Europe, notably Poland / Within five years, it is expected that up to half the population will be from BME communities.

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### Our BME population faces big issues...

#### Language

The size and diversity of the ethnic minority population makes it a priority to develop appropriate translation and interpretation services, particularly relating to new communities. We have had provision for the Indian, Pakistani and Bangladeshi communities for a long time. The weakness in the NHS is in 24-hour interpretation and translation facilities. We heard of one NHS hospital where a Moroccan Muslim woman, who spoke French, was admitted to a maternity unit at 4am to deliver a child. Her husband, a Muslim, could not be there by virtue of his beliefs. She could not understand English and a nurse wanted to convince her to have an epidural. The nurse found another woman, already under the influence of an epidural, who was a French teacher, and relied on her to convey the information.

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#### Undiagnosed conditions

There is a high incidence of heart disease, stroke and diabetes among Asian and African-Caribbean communities particularly, often undiagnosed. We screened 1,800 Asian people and found 70 new cases of diabetes. A large influx of people from HIV risk areas, notably Africa, means there is a community needing specialist sexual health support.

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### Our workforce needs...

#### Recruits from new communities

The workforce (38 per cent ethnic minority) broadly reflects the community. But new arrivals – such as Polish people – are under-represented.

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#### High-level promotion

About a fifth of the senior management team of 30 is from ethnic minorities. But representation is lower for board members. It is important to have BME people in decision-making positions to understand local issues.

## Capacity

We want to ensure that ethnic minority service providers are both given access to contract tenders and also have the capacity to compete seriously for contracts.

## Mental health services

We have a lot to learn about providing mental health services for people from BME communities. We undertook some positive action with a special worker providing mental health help for the Asian community. That led to complaints from the white community about preferential treatment. This episode raises questions about delivering race equality in this area.

## Monitoring service agreements

We need to work hard to ensure that we have enough checks on service agreements to ensure that race equality is properly addressed.

## Commissioning raises issues...

### Action Diabetes Project

Slough PCT established a partnership with Dr Foster, a private data collection agency, to target Slough citizens most likely to have diabetes. We converted a bus that went out into communities to promote diabetes awareness. On-the-spot checks discovered 70 cases needing follow-up.

### Health Activist Programme

This programme has trained 36 people from local communities in NHS practice. They go back to the communities, doing health promotion work and helping people to access services. The activists consult communities and relay difficulties back into the system.

### Community Needs Assessment Activist

These activists are trained to promote services to BME people over 50 years old and develop a better understanding of their needs.

### Maternity support

We employ a public health nurse to help people who are new to the country to register with a GP: she assists them to access primary care and, where necessary, refers them to sexual health, A&E and maternity care. She reports significant progress in early detection of TB via a fast track process and aims to improve antenatal care to pregnant women who may not otherwise access GP help.

## Next steps...

We need more creative ways to consult communities based on the Health Activist and Action Diabetes Programmes. We want to improve interpretation and translation services – we may start a team of our own translators and hire them out. To encourage more BME people into senior positions, we will expand mentoring programmes, fast-tracking and skills escalator programmes.

## Programme lead

**John Sailsman, Diversity Manager.**  
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# Race for Health

## South Birmingham PCT

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### Profile

The second most diverse city in the UK / Twice the national average of working-age women who have never worked / One in five people live with a long-term illness / In some wards, the majority of residents are Pakistani / There are some affluent wards and also some wards with high levels of deprivation.

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### Our BME population faces big issues...

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#### Marginalisation

In some parts of Birmingham, BME populations are concentrated in particular wards, so it is easier to target services at them. In south Birmingham they are sometimes more scattered, with, for example, small, Somali-, Chinese-, and Bengali-speaking communities that are isolated. So it is more difficult to make sure their needs are addressed.

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#### Disease risk

South Asian populations and African-Caribbeans face higher incidence of, for example, diabetes and coronary heart disease.

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#### Lack of opportunity at senior levels

It is difficult for BMEs to advance to the top jobs within the NHS, even if they have a long history of working for the health service. This poses a challenge to convince BME communities that the NHS is a good place to work.

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### Our workforce needs...

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#### Improved BME recruitment

In particular, the Bangladeshi and Pakistani communities are poorly represented. Of 895 administrative and clerical staff, 19 are Pakistani/Bangladeshi compared to 709 in the category of white British/mixed British. There is a perception within BME communities that the NHS is a white middle class organisation. People from disadvantaged communities with few formal qualifications find it hard to get good NHS jobs.

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#### Young people

Younger people are attracted to IT or private sector jobs and the NHS is perceived as a poor payer. The jobs open to BME staff appear to be more menial, with the clinical and managerial jobs apparently occupied by white people – not appealing to young BME people.

## **BME Leadership**

The PCT lacks a visible black leadership. The PCT is developing ways to develop its own BME leaders.

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## **Commissioning raises issues...**

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### **Reaching smaller BME communities**

It is a challenge to identify their needs and create services that are culturally sensitive to them and which do not ignore them.

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### **Data collection**

Data on ethnicity remains inadequate, making it difficult to measure the outcome of race equality interventions and identify real levels of inequity.

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### **Practice-based commissioning**

Many GPs, particularly in the more deprived wards, with the greatest concentrations of ethnic minorities, are single-handed. This makes it more difficult to create sophisticated commissioning for a patient-led NHS.

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## **We're proud of...**

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### **Work experience programme**

We run a work experience programme for teenagers, more than 70 per cent of them from BME backgrounds. Participants spend two weeks in the Trust on a semi-structured programme including three days on a placement of their choice, in, say, physiotherapy, the elderly wards and children's services. Two other days are spent elsewhere, for example in communications or finance. They also spend five days on issues such as diversity training, sexual health training, health and safety risk management. Some 50 school children have passed through the programme which will hopefully encourage BME recruitment.

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### **The Community Family Worker Programme**

It targets deprived wards to offer supported training (including childcare) to predominantly unemployed people. More than 180 participants have been trained as Community Family Workers. The majority are now working for the first time and coming off benefits. Their role is to help families that are disengaged from the NHS and to help make sure that services are reaching those in need.

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## **Next steps...**

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### **More funding**

We want core funding for community family workers/ para professionals – like the 180 that have been trained – to become part of district nursing teams and health visiting teams. This would involve a shift away from services being delivered solely by academically trained professional staff. Experience of the community, as well as professional qualification, should be given validity.

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### **Programme lead**

**Vicki FitzGerald, Para Professional Development Manager**  
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# Race for Health

## Wandsworth PCT

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### Profile

Second most populated inner London borough / Pockets of affluence beside pockets of deprivation / Over three times national (England & Wales) average of BME residents and over twice the national average of White Irish / More than 23 per cent from mainly Asian and Black backgrounds with a high prevalence of diabetes and hypertension; two major risk factors for CHD and strokes.

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### Our BME population faces big issues...

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**Poor neighbourhoods** BME communities often live in the most deprived wards. There are large numbers of asylum seekers and refugees.

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**Primary care** There is a high prevalence of hypertension and diabetes plus poor accessing of GPs, particularly among people for whom English is not their mother tongue. We need to work more effectively with the community to deal with their out-of-hospital primary care.

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**Lack of data** More detail required on these communities so that we know whether services and health outcomes are distributed equitably. Taking the decision to allocate resources to areas of greatest need is motivating us to focus on getting better information about deprived communities.

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**Loss of funding** Wandsworth is losing money in per capita allocation because it is considered a wealthy borough. This effects those who have real needs.

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**Youth** Wandsworth has a very young population. Forty per cent are in the 20-44 age group. Many young people are not registered with a GP and so make higher use of hospital A&E services.

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### Our workforce needs...

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**Career opportunity** We must ensure that we get the mix right in middle management which is often where our BME staff experience barriers to progression. BME people are substantially represented at director level of the PCT. BME communities have goodwill towards the NHS which must not be lost.

## **BME skills**

Wandsworth has a multi-ethnic staff forum. It works with BME staff to support their skills development and knowledge so they can progress within the organisation. There is informal mentoring of juniors by senior BME staff.

## **Commissioning raises issues...**

### **Using data**

We need to commission services using public health data rather than simply services commissioned historically. We know, for example, there are high numbers of Wandsworth residents with hypertension and diabetes.

### **Fairer distribution**

Working with GPs for a fairer distribution of services for BME communities.

### **Communication**

We need two-way dialogue between communities and GPs on what is needed. An area with many refugees may need services commissioned that include integrated language support as a matter of priority.

### **Health conditions**

So fewer people use A&E and more go to the GP in time.

## **We're proud of...**

### **Financial prudence**

Moving the PCT onto a firmer financial footing. We have to operate within our financial limitations. We are on the road out of deficit. By 2008 we will be in recurring balance.

### **Race equality scheme**

We've produced a robust scheme, and it's not just window dressing. We have made some inroads into creating understanding within the organisation that race equality is integral to what we do. The scheme requires organisations to review how they work – their mission statements, performance management objectives and procurement practices.

### **The PCT board cares**

It works well as a team and has accepted its responsibility for taking equality and diversity forward.

## **Next steps...**

We want our commissioning decisions based on public health data of our community needs. We will embed equality and diversity into the framework of the PCT. It is too easy, for example, for the diversity committee to become an information exchange rather than leading action. So the committee has reduced its meetings from four to two a year, with its role being to set priorities and review success, with actual implementation being the responsibility of managers and directors. We aim to maintain a stable organisation in the face of an uncertain NHS, so that progress is not lost.

### **Programme Lead**

**Margaret Adjaye, Diversity Facilitator, supported by Public Health**  
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# Race for Health

## Westminster PCT

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### Profile

One of London's most culturally diverse areas / Over 120 languages spoken / Disparities in health and wealth / Five of the PCT's 20 wards are ranked among the poorest 20 per cent in England / Life expectancy for men in Belgravia is 83 years while in Church Street it is 67 years - one of the country's largest gaps / Six out of ten BME children speak English as a second language / Westminster has now become home to many refugees and asylum seekers.

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### Our BME population faces big issues...

<b>Diverse population</b>	There is a wide range of communities from many different areas, including the Middle East, north Africa, Asia, Eastern Europe and South America. It can be difficult to collect information on so many groups. There is also a wide range between affluence and poverty, so the correlation between disadvantage and BME status also varies. Crude ethnic monitoring does not provide a sufficiently sophisticated picture of such diversity.
<b>Inequality</b>	The PCT has the one of the biggest variations in mortality rates anywhere in London – an 18-year difference between men in the richest and poorest areas, only a mile apart.
<b>Mobile populations</b>	New communities emerge rapidly and it is difficult to keep information on them up to date.
<b>Political agenda</b>	It focuses on choice and local commissioning. How can that work best for BME communities?

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### Our workforce needs...

<b>Cultural competence</b>	At lower grades, the BME proportion of the workforce is higher than in the local population. But there is snow-capping going up the organisation. Also, the workforce does not reflect the diversity of the BME community. It is likely that Middle Eastern, North African, Eastern European and South American
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communities are not well-represented.

### **Opportunity**

The PCT is working to improve employment opportunities for our community. Agenda for Change recently revamped the NHS job evaluation structure, but some groups of staff fared badly. This national issue particularly affects lower grades where there are many BME staff.

## **Commissioning raises issues...**

### **Lack of information**

It is difficult to commission the right services for the BME population because we don't have good enough data on such diverse communities.

### **Targeting certain conditions**

We have opened a new diabetes centre to improve local access. We also want to tackle, for example, smoking cessation – there is higher incidence of smoking and of smoking-related illness among our BME communities.

### **Access**

We need to make sure that BME communities understand how the NHS system works, are not hampered by language issues and receive services that meet their needs in terms of religion, language and ethnicity. That involves developing BME voluntary sector capacity, working with the PCT.

## **We're proud of...**

### **Good consultation**

The BME health forums that we fund and promote are a very positive achievement. There is now an effective dialogue. The next step is to respond more effectively to the issues that come out of the process.

### **Reviewing primary care**

Using the consultation arrangements we have on mental health, we are working to increase BME access to primary care. We are working with users – asking them their positive and negative experiences with GPs and surveying BME people who are not registered with GPs, to find out why they do not use GPs. We are also surveying professionals. All of this helps us understand better the barriers to good primary care for BME communities. We will then produce an action plan to reduce barriers.

## **Next steps...**

Next year, we will plan to get systems into practices to help GPs and clinical staff to monitor ethnicity of patients and then act upon what comes out of monitoring. We want to give front-line staff the results of monitoring so they know where the greatest need is. We will also provide staff with backup information to interpret their findings and translate them into practise.

On ethnic monitoring, we want to develop a one-stop intranet page telling people about the data on their activity, how it relates to local population and best practise in dealing with the issue.

### **Programme Lead**

**Brian Colman, Equality and Diversity manager**

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# Race for Health

## Wolverhampton City PCT

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### Profile

22 per cent black and ethnic minority population / The majority are Asian - Punjabi is the most popular minority language among 80 spoken in Wolverhampton / The African Caribbean community is next largest group / Health indicators suggest considerable disadvantage / Lower birth weight and higher than average infant mortality in the Asian population / Challenges include higher than average rate of type two diabetes among African Caribbeans / Higher incidence of CHD among Asians.

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### Our BME population faces big issues...

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#### Inappropriate health services

The community needs to access culturally appropriate services closer to home. For example, mental health is an issue for African Caribbean community: services are locally based but not all are culturally appropriate. The African Caribbean Community Initiative (ACCI) provides the only culturally appropriate service but is limited by capacity.

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#### Changes in factors effecting health

This is not just change in health services. This community needs better access to good transport, schools and employment, all of which have an impact on health.

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#### Aging population

There are increasing numbers of BME people over 60 with more than one life long condition, straining the capacities of families to provide care.

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#### Growing the voluntary sector

The community needs the development of greater capacity within the voluntary sector to enable the provision of culturally appropriate services, like ACCI and the Asian Women's Adhikar Association (AWAAZ) provides.

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### Our workforce needs...

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#### To understand racial equality properly

At the moment the concept is not thoroughly embedded in the workforce. It is important for people to recognise that racial equality is everyone's responsibility.

**Equality of opportunity** We provide some access to development and training but this isn't clearly linked to career progression.

**Use of equality impact assessment** Our workforce needs to use this tool when evaluating services and service provision. Patient and users should be involved in such assessments.

## Commissioning raises issues...

**Cultural competence** Are there good enough locally based/delivered services that understand the culture within which they work and which have the capacity to deliver?

**Standards and procurement** Smaller organisations are increasingly able to provide services on a smaller scale. However, being able to include them in appropriate commissioning procedures can create problems in terms of procurement and guaranteeing standards. Larger traditional organisations may find it easier to negotiate contracts thanks to their experience of delivering services.

## We're proud of...

**The Health Trainer Programme** The programme will develop NVQ-style training packages for local people to help them to promote health services within their community. They will be trained to identify health needs and steer people to services.

**Skill-swapping with voluntary sector** The PCT has begun developing a programme for sharing training opportunities with the voluntary sector. For example, staff in the voluntary sector will be able to shadow our finance staff to improve their skills.

**Walking for health** We have an Asian group and African Caribbean voluntary group undertaking a walking for health programme, organising walks for their communities.

**Healthy cooking class** The PCT funds one, run by the African Caribbean Community Initiative.

## Next steps...

**Expert Patient** The PCT wants to increase the involvement of patients and carers in the management of their own health by using the Expert Patient Programme. We intend to pilot this in the African Caribbean community by developing the ACCI carers' project to support carers in their own health care.

**Better employment Programme** The PCT intends to improve the ethnic monitoring of its recruitment processes. It will look at not only centralised recruitment processes but the PCT's marketing programme and the schools involvement programme

**Local involvement monitoring** We want to know what people from ethnic minorities would like to see developed within the PCT. So the trust PCT plans to run a conference for Race for Health, showcasing what has been achieved.

**Programme Lead**

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