



**COHESION,  
DIVERSITY,  
EQUALITY  
CONFERENCE  
SEMINARS**

# Policy into Practice Seminars: (2) Health

Chair: Dr Richard Stone

Presentations:

Sharon Grant, Chair of the Commission for Public and Patient Involvement in Health  
Shun Au, Chair of the Chinese Mental Health Association

Note takers: Anisa Niaz and Don Flynn

## Presentations

**1. Sharon Grant.** For over 20 years there has been evidence of racial inequalities in the health services. Statistics show the generally poorer health of black and minority ethnic people, their greater likelihood of suffering from major 'killer' diseases, high incidence of mental health problems, lower levels of satisfaction with services, and sharp differences in peri-natal mortality.

There is a strong perception of exclusion amongst BME people, in respect of waiting times, understanding explanations offered, trust in the doctors and nurses, being treated with respect, and being given help with pain relief. Barriers to access include ignorance, language and literacy difficulties, cultural differences (relating to religion, gender or work patterns), different needs of different BME groups, and location of services.

The NHS is popularly regarded as embodying the principles of equality and citizenship in British society. Provision of inclusive and free services to all is a practical example of how citizenship can have real meaning for ordinary people. BME communities have grounds for feeling excluded from the NHS and this has consequences for wider feelings about their place as UK citizens.

How can we mainstream race equality issues in the health services? The performance framework of the Race Relations (Amendment) Act 2000 requires health authorities to demonstrate performance on race equality, and issues of leadership, workforce motivation, finance and

procurement policies, patient and public involvement strategies. The CRE's Code of Practice guides, intended to influence the policies of the authorities, are a potentially useful tool for the work of promoting equality.

**2. Shun Au.** The special health problems of BME groups involve mental health issues, heart disease and the poor health of older people. Extra stress results from working long hours for low wages while raising families. Concern for health issues is often the catalyst for the formation of community organisations amongst BME communities, representing their needs to professionals and health authorities.

Health services rarely focus enough on these issues. Early consultation is needed when planning services, with special focus on BME groups. More specific services are needed, with procedures for checking on outcomes and feedback. Appropriate commissioning procedures for health services could be used to bring about change. It would be necessary to identify providers, make use of greater flexibility in procedures, and push for monitoring systems and better evaluation. It can be done.

*Part of a video on these issues made by the Chinese Mental Health Association was screened.*

## Discussion

**BT:** Devolution within the NHS is posing problems for the provision of healthcare services to BME communities. Primary Care Trusts (PCTs) are working separately in their own areas. Joint commissioning across PCT boundaries and joint work by BME organisations is needed.

**SP:** 90% of Britain's 57 million inhabitants come into contact with the NHS and share in its £45 billion annual budget. Government strategies operate at national level; for race equality work to be more effective – those strategies must act at a local level.

Ward-by-ward characteristics of local populations are needed to test concerns about deprivation. Without detailed local research, national strategies will be redundant.

**MHK:** NHS money is devolved to the PCTs who have little understanding that BME communities are dynamic and extend across boroughs and towns. Joined-up working is required.

**WI:** Race equality impacts on the work of nurses through the 'demographic time bomb' and the dependence of a growing elderly population on nurse-provided services. Organisations such as the RCN are not given a major role in policy discussions, despite being a crucial link between patients and community care. Partnership between nurses, patients (and representative organisations) is needed if progress is to be made.

**RP:** Faith communities' needs can be seen particularly in respect of women and elderly people who may require, for example, female carers. The needs of faith communities must be properly met.

**DF:** Recent changes in regulations have led to withdrawal of GP and primary care services from many categories of refugees and migrants – TB, HIV and cancer go untreated. Consider the implications of serious health conditions not being treated in areas of immigrant and refugee settlement.

**AN:** Social services should be the main providers of health care services to BME elders, but because such care does not take specific cultural needs into account, community organisations are forced to provide mainstream care. Social care should always be scrutinised for its race equality impact.

**SP:** A few boroughs are making efforts to find carers from appropriate backgrounds to care for BME elders.

**RE:** The difficulties of providing carers for BME people relate to the recruitment numbers problem in general. The change in regulations to allow direct payment to family members providing care has helped.

**SP:** Institutional racism has been discussed for a long time but government responses tend to be bland. The section on 'reducing health inequalities' in the new government strategy is just one example. Why is there so little progress on dealing with the problem of racism within the NHS?

**MM:** The government has disappointed us in its response to the Bennett Inquiry Report, ignoring its major recommendations. There must be the will to challenge racism in the NHS.

**RR:** Race equality measures are being promoted in a climate of negative

**Richard Stone (to the left of the screen) chairs the Health Seminar, with Shun Au and Sharon Grant at the table (top right)**



policies emerging from the Home Office, the DoH and the criminal justice system, contradicting the positive proposals set out in the race equality strategies. We need to see more evidence of consensus and joined-up thinking across government departments.

**RW:** Commissioning processes for health service provision should cover capacity-building for BME communities and organisations which deliver services. BME groups should be involved in consultation procedures at the very earliest stages.

**MR:** In Tower Hamlets people are not being treated for epilepsy, HIV and TB because of their immigration status. Some treatments may have to be met from community health budgets as a consequence. Not providing healthcare because of uncertain immigration status is a human rights abuse.

**Sharon Grant:** None of these issues is new. The government's published strategy on race equality and community cohesion should approach inequality in a systematic way by setting targets that must be met in order to retain funding. BME organisations will also be expected to meet these targets. The Health Care Commission recently published a document on achieving five separate standards in the NHS. This is potentially an opportunity to address equality issues. As well as the Health Care Commission we should think about the role of the Audit Commission, which is responsible for monitoring how the

money is spent.

We need to maintain pressure from below. The Commission for Patient and Public Involvement in Health was set up to represent patients' interests. Local forums across the country are to relay information about needs, but at national level the Commission is being abolished. This will be an obstacle to bringing together BME groups across PCT area boundaries.

**SP:** What is the CRE's role in this area, and who is responsible for addressing the health inequalities set out in, for example, the Bennett Inquiry Report? There is rising anger that in response to critical reports being produced, reports which require action from the authorities, there continues to be no implementation of recommendations.

**Shun Au:** We need a national and regional structure for funding BME organisations. We also need a departmental structure which allows people more flexible work options to keep their career options open. A reluctance to provide core funding for small organisations leaves many under-resourced on administration.

**RP:** Lack of coordination between services at the local level makes it important to stress the need for the empowerment of local communities and early involvement in planning.

**BM:** Health issues are not so much about enhancing life-chances, but the chance to live. Immigration status is also a public health issue. Most doctors

and nurses believe in human rights and view these issues as integral to their work. Recruitment of staff and the often unused skills of asylum-seekers are very relevant to the debate about inequality in health.

The need for joined-up policy and work across PCT boundaries is clear, and we should press for structures to facilitate this. The role and funding of the voluntary sector needs to be emphasised: the NHS can never be as efficient as, for example, the Chinese Mental Health Association.

**Richard Stone (Chair's Summing-up)** Ideas to emerge from the discussion include:

- Funding for equality work should be based on a fixed percentage of the NHS budget and should include an element for core funding.
- There is clear concern about the vulnerable position of asylum-seekers and immigrants. NHS services should be provided to everyone resident in the UK.
- Information about good practice should be shared, and a joined-up approach should be taken. An NHS interactive website could be useful for this purpose.
- Racism between patients needs to be addressed – perhaps through the use of group psychotherapy – and anti-racism policies enforced.
- New ways to hold the NHS to account are needed – particularly since the abolition of the community health councils.
- There is a pressing need for a BME-led campaign in the area of mental health services. □

*social and cultural capital, and we have paid too little attention to this area'.*

Some schools may have powerful community strategies but require parental support for their existing agenda. Addressing the needs/issues of children has to be about adopting a less rigid or fixed way of operating, e.g. adapting the National Curriculum to meet the needs of the children.

Professor Dyson offered three examples of schools' responses to addressing the issues of gender, diversity and aspirations:

- trying to involve communities/families in supporting different expectations of family and school;



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## Policy into practice seminars: (3) Education

**Chair:** Sahsi Sivaloganathan, Vice Chair, General Teaching Council for England  
**Presentations:**

**Alan Dyson, Professor of Education, University of Manchester**  
**Keith Ajegbo, Headteacher, Deptford Green School**

Note takers: Nicola Rollock and Olivia Skinner

### Presentations

#### 1. Alan Dyson on the Wider Role of Schools.

Professor Dyson has focused his research on education in an 'urban context', examining the relationship between schools and the communities they serve. His presentation focused on his research into 'full service' or 'extended' schools.

The full schools initiative requires schools to be involved in more than what has traditionally been seen as the core business of teaching. Community services will often be on a school site, and schools may thereby have direct involvement in other areas such as health, housing and employment. Schools are redefined as developers of their pupils' potential or

'capital', which can be categorised as:

- human capital – what pupils bring with them when they first enter the education system;
- cultural capital – knowing how to be, being part of more than one cultural group, learning how to be learners;
- social capital – how resources connect with networks of people, opening up new horizons of opportunity, thought and connection.

Models were provided of how certain schools defined the needs of their pupils, families and the wider community: 'Children come to school already locked into all kinds of



**(L-R) Keith Ajegbo, Sahsi Sivaloganathan and Alan Dyson**