BME Equity and the NHS - Time for Action

Friday 6 June 2014

Conference Report
London Hilton, Park Lane, London W1K 1BE
FOREWORD

On 6 June 2014 the NHS BME Network held its annual conference entitled “BME Equity and the NHS - Time for Action”, at the London Hilton Park Lane. The conference was attended by over 300 delegates with seventy-five percent of the delegates being employed by the NHS; twenty percent BME users of services and the other five percent non-BME users of services.

The conference was held in response to the fact that all available evidence, over the last few years in particular, clearly shows that the delivery of the race agenda has become somewhat “diluted” in the NHS. This was supported by conference presentations which revealed that BME staff face more disadvantages and discrimination in the workplace than ever before and the positive action initiatives to increase the number of BME Leaders in the NHS have failed to deliver any real benefits. Similarly the provision of NHS services has failed to deliver any real improvements in the health and wellbeing of BME communities and ethnic health inequalities remains a major concern.

Over a decade ago the Department of Health (DH) published its Ten Point Race Equality Action Plan and we were assured that the NHS would give greater prominence to race equality by striving to reduce health inequalities; making race an important dimension of health strategy and targeting recruitment and development opportunities at BME people in recognition that their skills are often underused. However, when the delegates were asked to vote whether BME equity in the NHS was a reality in 2014 an overwhelming seventy-six percent of delegates answered “No” and of the remaining twenty-four percent of voters thirteen percent answered “don’t know”.

It is clear from the discussions that took place on the day that achieving BME Equity in the NHS will require changing the way health services are commissioned, delivered and managed. During the question and answer session seventy-five percent of the delegates voted they did not believe that the current NHS strategy could deliver race equality and the top three barriers for achieving race equality were institutional racism; lack of diversity on Trust Boards and senior management and a lack of commitment. Furthermore, eighty-eight percent of delegates stated that a new strategy was required.

It is also evident from the discussions that took place on the day that BME people need to contribute and be involved in the development, implementation and performance management of NHS strategies. As such ninety-eight percent of the delegates voted that BME users of services need to be empowered to facilitate this and ninety-three percent voted that for BME equity to become a reality more diverse leadership in the NHS was necessary and positive action initiatives are required to address the institutional racism which exists.

Furthermore, ninety-eight percent of the delegates voted that the Care Quality Commission needed to do more to address the institutional racism that exists in the NHS given the impact on patient safety. In response to the concern of the delegates Professor Sir Mike Richards as the Chief Inspector of Hospitals made a commitment to the delegates that he would work in partnership with the Network and attend its annual conference on 12 June 2015.
The notes from the various workshops that took place on the day show that the roles and responsibilities for achieving race equality in the NHS for all parties are clear and concise provided the partnerships are based on equality and mutual respect given the power differentials.

The NHS Constitution states that the NHS belongs to us all and for this reason the delegates agreed that the NHS BME Network should “fight” to retain the right to use the NHS logo as an integral part of its logo.

The Constitution “establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.”

The number one principle of the NHS as outlined in the Constitution is that NHS will provide a comprehensive service, which will be available to all people irrespective of their background including race and as such it was agreed by all present on the day that over the next twelve months the NHS BME Network should focus on establishing itself nationally to deliver on its vision “to be an independent and effective voice for BME staff, patients, service users and carers to ensure the NHS delivers on its statutory duties regarding race equality”. Furthermore, we agreed that our conference next year should focus on the outcomes we intend to achieve in the interim.

Clearly the time for action is now!

Yours

Vivienne Lyfar-Cissé
Chair
NHS BME Network
‘BME Equity and the NHS: Time for Action’

Earlier this month, the NHS BME Network organised a conference entitled ‘BME Equity and the NHS: Time for Action’ held at the Hilton Hotel in London. The national conference created a great opportunity to discuss what needs to be done to promote greater equity for BME staff and patients within the NHS. The event covered various topics including bullying, the lack of career progression, quality of care, the issue of whistle blowing and the failure to access training programmes.

The conference started with the bold question of, “Is BME equity a reality in the NHS today?”, of which 76% of people said no, demonstrating that resolving the discrimination and inequalities experienced by BME staff and patients is still a huge challenge.

Victoria Macdonald, the Chair of the debate and the Health and Social Care Correspondent for Channel 4 News stated:

“There is an overwhelming feeling that I have as I have talked to people around the room that this issue of course is taking too long, people are saying that there is a lot of talk and not enough action and also why are we still here in 2014 having these discussions. Today is the time for action and you have to be the driver - a force for change.”

Julie Bailey, founder of Cure the NHS and a central figure in the Stafford Hospital scandal, relayed a very powerful story:

“I had no idea 7 years ago that my local hospital was not safe and I had no idea that older people feared going in to some NHS hospitals, and then I had no idea that some people feared going home alone when they went out of the NHS hospital. I wish I could stand here and tell you that after 7 years of campaigning for a safer NHS that it is safe - it isn't, but I think we have moved a long way forward. But we have still got a hell of a long way to go.”

Julie Bailey’s mother, Bella Bailey, died on 8 November 2007, due to inappropriate care and staff who were not trained properly.
Roger Kline, a research fellow from Middlesex University Business School talked about the link between the treatment of BME staff at the NHS and the patient experience. He stated:

“Simon Stevens, who is the new Chief Executive of the NHS, said that of his last three bosses, none of them were from the NHS. And it has to change. I think that building a new requirement to close that gap is the way forward, we are all patients, nothing less.”

A race equality review of NHS organisations in the then South East Coast Region in 2008 by Dr Vivienne Lyfar-Cissé, Chair of the NHS BME Network, showed that BME staff were disproportionately represented on all HR procedures and under-represented at senior management levels. More recent research by Kline revealed that despite leadership programmes targeted for BME staff, there are now fewer leaders from a BME background than in 2006. Furthermore, the stark absence of any BME representation at the Executive Director level of any of the regulatory bodies, means that there are real concerns, if effective changes will be implemented to bring about a more equitable representation of BME staff at senior levels within the NHS.

Professor Sir Mike Richards, Chief Inspector of Hospitals at the Care Quality Commission, said that he was there to listen and stressed that more training on equality and talking to specific equality groups is necessary, however the audience was not entirely impressed by this response.

The combination of workshops and panels resulted in an overall positive outcome as delegates reaffirmed their commitment to look for good practice, improve strategies, challenge existing practices and as patients and staff members, demand their rights. Just the very title of the conference: ‘Time for Action’, inspired and motivated everyone as speakers, panellists, volunteers and delegates demonstrated a true passion which filled the room.

However, it is important to note that it is not enough to just hope that this all will be put into practice, because indeed it is not. It is crucial to demand a new change, develop better strategies and plans, get a place at a table and be determined that your voice will be heard, until this issue is gone completely.

As Dr Vivienne Lyfar-Cisse, the Chair of the NHS BME Network said:

“Sometimes the door just shuts in your face, but we are ready to keep on knocking until it opens.”
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<td>Registration and Refreshments</td>
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<td>09.00 - 09.10</td>
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<td>Canterbury Christ Church University</td>
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<td>09.10 - 09.30</td>
<td>BME Equity and the NHS - The Reality</td>
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<td>09.30 - 10.00</td>
<td>The Toxic Mix of Race Discrimination and Patient Safety</td>
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<td>10.00 - 10.30</td>
<td>Quality of Care - Putting Patients First</td>
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<td>Professor Sir Mike Richards</td>
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<td>10.30 - 11.00</td>
<td>Ethnic Inequalities in Health - A View from NHS England</td>
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<td>Chair - Becky Aldridge</td>
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<td>Dorset Mental Health Forum</td>
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<td>Workshop 4 - Hear Me Now - Prostate Cancer in Black Caribbean and Black African Men</td>
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<td>Chair - Rose Thompson</td>
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<td>BME Cancer Communities</td>
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## Conference Programme - Afternoon Session

**14.00 - 14.20**  
**Values Based Commissioning**  
*Emeritus Professor Chris Heginbotham OBE*  
Professor of Mental Health Policy and Management  
University of Central Lancashire

**14.20 - 14.40**  
**Ethnic Inequalities in Health - Why we need to look Beyond the NHS**  
*Professor James Nazroo*  
Professor of Sociology  
University of Manchester

**14.40 - 15.00**  
**Why the NHS needs to be Cured**  
*Julie Bailey*  
Cure the NHS

**15.00 - 15.15**  
**Refreshments**

**15.15 - 16.40**  
**Debate - How can BME Equity in the NHS be Achieved?**

**Chair**  
*Victoria Macdonald*  
Health and Social Care Correspondent  
Channel 4 News

**Participants**  
*Marguerita Alexander*  
BME Service User  
King’s College Hospital NHS Foundation Trust

*Sue Jackson*  
BME Service User  
North East London NHS Foundation Trust

*Dr Greg Kalu*  
Consultant Obstetrician and Gynaecologist  
Secretary  
NHS BME Network

*Roger Kline*  
Research Fellow  
Middlesex University Business School

*Professor James Nazroo*  
Professor of Sociology  
University of Manchester

*Ruth Passman*  
Deputy Director Equality and Health Inequalities  
NHS England
Conference Programme - Afternoon Session (Contd.)

16.40 - 16.55  Conference Summary
Victoria Macdonald
Health and Social Care Correspondent
Channel 4 News

16.55 - 17.00  Closing Remarks
Dr Vivienne Lyfar-Cissé
Chair
NHS BME Network

Conference Programme - Evening Session

19.30 - 20.00  Pre-dinner Drinks
20.00 - 03.00  Conference Dinner
03.00 - 03.00  Close
PRESENTATION 1

BME Equity and the NHS - The Reality

Dr Vivienne Lyfar-Cissé
Chair
NHS BME Network

Dr Vivienne Lyfar-Cissé is currently employed as a Principal Clinical Biochemist by Brighton and Sussex University Hospitals (BSUH) NHS Trust. In 2009 at the request of the Trust Board she led on a transformational change programme entitled Commitment to Change (C2C) Agenda for Race Equality to address the institutional racism in the Trust. This work contributed to towards her MBA qualification (with distinction) in Health Service Management.

Dr Vivienne Lyfar-Cissé is the current Chair for the BSUH NHS Trust BME Network. She has also led on the development and Chaired a number of BME Networks including the Surrey and Sussex BME Network; the South East Coast BME Network and was the Transitional Lead for the NHS BME Network before being elected Chair of the Network in 2012.

As a devoted Christian Dr Vivienne Lyfar-Cissé is both passionate and committed to moving the Race Equality Agenda forward in the NHS both at a regional and national level. It was her faith, passion and commitment which gave her the determination to complete the first Race Equality Service Review Report in the NHS published in July 2008 on behalf of the South East Coast BME Network against incredible odds.
Sir Macpherson defined institutional racism as:

“the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be detected in processes, attitudes or behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people”

South East Coast BME Network Race Equality Review 2008

BME Communities

A failure to:

- Collect ethnic monitoring data for patients and service users
- Engage and consult BME communities
- Address the health needs of BME communities
- Address barriers to access

BME staff make up 15 per cent of the workforce

- BME staff disproportionately represented on disciplinaries; grievances; bullying and harassment; capability and employment tribunal
- BME staff less likely to be appointed from a shortlist
- BME staff grossly under-represented at senior management level and over represented at AfC payband 5
- Failure to collect, record and analyse workforce data or undertake race equality impact assessments
PRESENTATION 1

Joints Strategic Needs Assessments (JSNAs)

Local Government Improvement and Development’s review of JSNAs found that whilst the document addresses socio-economic issues it does not readily address race equality (ethnicity)

Equality and Diversity Council

- Equality and Delivery System (EDS2)
- NHS Values Summit
- Personal, Fair and Diverse Campaign
- Education programmes to encourage more diverse leadership in the NHS

What is the reality?

Ethnic Health Inequalities

- Generally poorer health among non-white minorities, with Bangladeshi people having the poorest health, followed by Pakistani, Black Caribbean, Indian and Chinese people
- High, but variable rates of diabetes across all non-white groups
- High rates of heart disease among “South Asian” people, but particularly among Bangladesh and Pakistani people
- High rates of hypertension and stroke among Caribbean and African people
- High rates of admission to psychiatric hospitals with a diagnosis of psychiatric illness for young Black Caribbean men

1998 Acheson Report

Three recommendations for reducing ethnic health inequalities

- Policies on reducing socioeconomic inequalities should consider the needs of BME group
- Services should be sensitive to the needs of BME Groups and promote awareness of their health risks
- The needs of BME groups should be specifically considered in providing and planning healthcare

NHS England’s Approach to Health Inequalities

- Targeted approach
- NHS Values Summit
- Integration of care and services
- Making Every Contact Count initiative
- EDS2

Evidence shows that institutional racism remains a real problem for BME staff employed by the NHS

How can EDS be working?

- Personal, Fair and Diverse Campaign
- What has happened to equality?

- In 2012 just 1% of NHS Chief Executive came from a BME background
- BME Leadership programmes have failed!

1998 Acheson Report

2001 Explicit Targets set for reducing health inequalities

2002 Governmental Review

2003 Programme for Action

2010 Marmot Review

1998

2001

2002

2003

2010

Targeted approach

NHS Values Summit

Integration of care and services

Making Every Contact Count initiative

EDS2

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Friday 6 June 2014

London Hilton

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W1K 1BE

www.nhsbmenetwork.org.uk
**Policy Failures concerning Ethnic Health Inequalities**

1. Assumption that ethnic health inequalities is addressed solely by dealing with socio-economic status
2. Failure to consider ethnicity or ethnic diversity specifically
3. Targeting risk behaviours and health damaging 'life choices'
4. Failure to recognise the impact of racism and/or fear of racism

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**Ethnic Health Inequalities in Mental Health**

- Delivery Race Equality (DRE)-2005-2010
  - 12 anticipated outcomes including:
    i. A reduction in the disproportionate rate of admission of people from BME communities to psychiatric inpatient units
    ii. The prevention of deaths in mental health services following physical intervention
    iii. A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services

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**Delivering Race Equality contd-**

- Key Features:
  - Death of David Rocky Bennett in 1998
  - Community Development Workers (CDWs)
  - Count me in Census

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**Failures of the DRE Programme**

- Delay in appointing the target 500 CDWs
- Lack of commitment at the local level
- Lack of a national implementation programme
- Poor conceptualisation of roles
- Subversion of the programme’s vision by those not sympathetic to prioritising race equality issues

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**Rights and Wellbeing of Racialised Groups (RAWORG)-2011**

**Examples of Reasons for BME Inequality in Mental Health**

- Institutional racism in society and services
- Ineffective therapies and inappropriate help
- Research and practice that has stereotyped and disempowered
- Lack of training and development of frontline staff

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**RAWORG-2011 contd-**

- Systems that are not designed to promote equality
- Lack of leadership
- Failure to acknowledge service user/survivor leadership in driving organisational change
- Lack of commitment from government and some professionals regarding promises for policy changes
- Suspicion that addressing race inequality will overlook other forms of inequality

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**Closing the Gap**

**Priorities for Essential Change in Mental Health**

- Aims to bridge the gap between the government’s long-term ambition and short-term actions.
- Twenty-five priorities where fastest changes are required including:
  i. Commissioning services to meet the needs of BME communities
  ii. Tackling inequalities around BME access to psychological therapies
- How will this be achieved???
PRESENTATION 1

Commissioning Cycle

NHS CONSTITUTION

Thank you
PRESENTATION 2

The Toxic Mix of Race Discrimination and Patient Safety

Roger Kline
Research Fellow
Middlesex University Business School

Roger Kline is Research Fellow at Middlesex University Business School, a Director of Patients First (the NHS whistleblowers network) and an Associate of Public World. Roger has worked for eight trade unions at senior level in the public, private and voluntary sector. His main interest is in changing the workplace culture in the NHS and social care and his two main areas of interest are in whistleblowing and workforce race discrimination. He is co-author of Professional Accountability in Social Care and Health: Challenging unacceptable practice and its management (2012) and The Duty of Care (2013). He is author of Discrimination by Appointment (2013) on race discrimination in the NHS recruitment and the author of The snowy white peaks of the NHS (2014) mapping the further deterioration of BME presence in leadership positions across the NHS. Forthcoming publications include analyses of the role of trade unions and HR in Mid Staffordshire. Roger is actively involved in supporting individual staff and in campaigning to seeking system wide change in the NHS.
NHS race discrimination: an issue for all patients

Roger Kline
Research Fellow
Middlesex University Business School

The snowy white peaks found...

• 1 in 40 chairs and no CEO in London is BME
• 17 of 40 Trusts have all white Boards but over 40% of workforce and patients are BME
• Decrease in BME Board members
• Not one BME exec director in Monitor, CQC, NHSTDA, NHS England, NHSLA, HEE
• Decrease in BME senior managers and nurse managers in recent years but Minister says: “Although these are not substantive rises, this demonstrates that we are travelling in the right direction.” Earl Howe February 10th

The treatment of staff.

• White staff 1.74 times more likely to be appointed once shortlisted than are shortlisted BME staff (Kline 2013)
• BME staff twice as likely to enter disciplinary process and more likely to be disciplined for similar offences (Archibong et al 2010)
• Black nurses take 50% longer to be promoted than white nurses (RCN)
• BME staff less likely to access national training courses

And patients

• “2% of mothers treated at the maternity unit in 2008 came from ethnic minorities but 83% of “serious untoward” cases involved ethnic minorities.”
• Daily Telegraph 12.09.2011 on Furness General Hospital

Staff survey confirms what the data shows

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<th>Key Finding</th>
<th>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public</th>
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<th>BME %</th>
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<td>Key Finding 28.</td>
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Patient care and leadership

“the overwhelmingly prevalent factors were a lack of staff, both in terms of absolute numbers and appropriate skills, and a lack of good leadership”.

“Something that worries me more than anything else in the NHS is bullying... permeating the delivery of care in the NHS... caused by the NHS’s “hierarchical” culture”

Ian Kennedy 01.04.2009

The cost to staff

W% | BME %
---|---
28 | 29
21 | 26
90 | 77
9  | 25

Key Finding 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public.
PRESENTATION 2

Six reasons why workforce race discrimination is bad for all patients
- Prevents patients getting best staff
- Impact diverts resources from patient care
- Discrimination makes staff ill
- How staff are cared for impacts on care they provide
- Diversity improves innovation + teamwork
- Unrepresentative Boards less likely to provide patient focussed care

Race discrimination can prevent patients getting best possible staff
- Patients may be prevented from getting the best clinicians and support staff if candidates’ ethnicity unfairly influences recruitment and promotion or leads to BME staff being unfairly treated in the disciplinary process or in other aspects of their working life.

Discrimination wastes money that should go on patient care
- If BME staff are treated unfairly then that is likely to have an impact on morale, productivity and turnover
- It will also lead to the loss of time and money through grievances, employment tribunals and reputational damage
- Bullying undermines patient safety
- UCLH calculation

Race discrimination makes staff sick
Everyday Discrimination: positively associated with:
- coronary artery calcification (Lewis et al., Psy Med, 2006)
- C-reactive protein (Lewis et al., Brain Beh Immunity, 2010)
- lower birth weight (Earnshaw et al., Ann Beh Med, 2013)
- cognitive impairment (Barnes et al., 2012)
- poor sleep (subject & object) (Lewis et al., Hlth Psy, 2012)
- visceral fat (Lewis et al., Am J Epidemiology, 2011)
- Discrimination, like other stressors, can affect health through both actual exposure and the threat of exposure

If those who care are not cared for, then patients will suffer
- An established link between the treatment of BME staff and the care patients receive.
- “Research suggests that the experience of black and minority ethnic (BME) NHS staff is a good barometer of the climate of respect and care for all within the NHS.
- ‘Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received” NHS Staff Management and Health Service Quality Results from the NHS Staff Survey and Related Data West, M et al,(2012)

Healthcare innovation hindered
- There is evidence of a link between diversity in teams (at every level including Boards) and innovation. At a time when the NHS needs to transform its care, lack of diversity may carry a cost in patient care for everyone

The current “strategy” has failed. We need a new one.
- Local employers (with honourable exceptions) look the other way
- Things have got worse not better
- It’s a patient care problem but we don’t treat it like other patient care problems
- No incentives, no sanctions, little learning, or monitoring
- A “blame” culture not a just culture
- No use of commissioning or regulation
- Little understanding of what works

Patient centred care requires diversity
- Leadership bodies which are significantly unrepresentative of their local communities, such as NHS Trust Boards, will have more difficulty ensuring that care is genuinely patient centred
- Resultant failings in the provision or quality of services to specific local communities that have particular health needs, including BME communities and patients
PRESENTATION 2

How might we know we may have a problem?
- Staff survey data on bullying, career development and discrimination
- Workforce data on BC composition cf. Trust composition, Recruitment likelihood, Discipline Discretionary pay and Non mandatory training
- Board composition compared with local community
- Patient survey data

Thank you
@rogerkline
Research Fellow
Middlesex University Business School
Sir Mike Richards was appointed as the First Chief Inspector of Hospitals for England at the Care Quality Commission (CQC) in July 2013. He has been asked to lead a new programme of inspections across acute hospitals, mental health services, community services and ambulance services both in the NHS and in the independent sector.

The new inspection programme involves a radically new approach for the CQC with large teams of clinicians, patients, carers and CQC inspectors visiting NHS Trusts. Each inspection will lead to a rating for service: outstanding, good, requires improvement or inadequate.

Prior to joining the CQC Mike was Director for Reducing Premature Mortality at NHS England (2013/14) and National Cancer Director at the Department of Health (1999-2013). Prior to these appointments Mike was a consultant and Reader in Medical Oncology at Guy’s and St Thomas’ NHS Trust (1986-1995) and Professor of Palliative Medicine (1995-1999).

Mike was appointed CBE in 2001 and Knight Bachelor in 2010.
Overview of presentation

1. CQC’s purpose and role
2. A Human Rights approach
3. Our new hospital inspection programme
4. Building equality, diversity and human rights into the new programme
5. What we still need to do

Our purpose and role

Our purpose
We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role
We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Human Rights Approach

• CQC has an organisational principle that we “promote equality, diversity and human rights”.
• We aim to weave equality and human rights throughout the way we regulate by applying our human rights approach appropriately to each type of service.
• We do this because we know that patients will only receive high quality care if providers address issues of equality. It is essential, not an “add-on”.
• The human rights approach is based on 7 human rights principles: Equality, fairness, respect, dignity, autonomy, right to life and human rights for staff working in services.
• We are currently reviewing our approach following a consultation period, but initial responses have been positive.

Our New Approach

We ask these questions of all services:
- Is it safe?
- Is it effective?
- Is it responsive?
- Is it caring?
- Is it well led?

The new CQC hospital inspection programme

• We recognise that the previous CQC approach was flawed – but it had good elements, in particular in relation to rigorous evidence gathering.
• We have built on the Keogh Reviews process for 14 acute hospitals with high mortality.
• We have brought together the best of both approaches (and more).
• We aim to be robust, fair, transparent and (hopefully) helpful.

Selection of Trusts

• All trusts will be inspected by December 2015.
• In the first wave, we deliberately chose some high risk, some low risk and some intermediate to assess our “Intelligent Monitoring” tool and to assess the range of quality in English hospitals.
• We are now prioritising ‘high risk’ trusts, but also assessing FT aspirants and some specialist trusts (e.g. children’s hospitals, orthopaedic).
CQC's 5 key questions

Safe? Are people protected from abuse and avoidable harm?

Effective? Does people's care and treatment achieve good outcomes and promote good quality of life, and is it evidence-based where possible?

Caring? Do staff involve and treat people with compassion, kindness, dignity and respect?

Responsive? Are services organised so that they meet people's needs?

Well-led? Does the leadership, management and governance of the organisation assure the delivery of high-quality patient-centred care, support learning and innovation and promote an open and fair culture?

8 Core Services

The following 8 core services will always be inspected:

1. A&E
2. Medical care, including frail elderly
3. Surgical care, including theatres
4. Critical care
5. Maternity and family planning
6. Children and young people
7. End of Life Care
8. Outpatients (selected)

We will also assess other services if there are concerns (e.g. from complaints or from focus groups).

The inspection team will split into subgroups to review individual areas, but whole team corroboration sessions are vital.

Inspection Teams

Chair
Team Leader
Doctors (senior and junior)
Nurses (senior and junior)
AHPs/Managers
Experts by experience (patients and carers)
CQC Inspectors
Analysts
Programme management support
Total: Around 30 people

Listening to staff

We always take note of whistleblowers, as this can tell us about the openness/culture of a trust and may point to specific areas of concern.

We cannot commit to resolving issues raised by whistleblowers, especially when these date back several years.

Focus groups with junior doctors, senior doctors, junior nurses, senior nurses, AHPs and administrative staff provide us with rich information on the safety, effectiveness and culture of a trust.

We will consider specific focus groups for BME staff if particular concerns have been raised.

Listening to patients and the public

We always hold at least one patient/public listening event at the start of each comprehensive inspection.

If the trust has multiple locations we normally hold separate events in the relevant localities.

We also hold specific events aimed at particular communities whenever possible.

Where particular concerns are raised by groups of patients we are increasingly holding specific listening events to understand their concerns.

Rationale for ratings

The public want information about the quality of services presented in a way which is easy to understand.

The approach taken by Ofsted is seen as a model, though we recognise that hospitals are more complex than schools. Patients/public may, for example, be interested in a particular service (e.g. maternity or frail elderly care) rather than a single global rating.

Ratings of services and of Trusts should hopefully be a driver for improvement.

Ratings: Approach (1)

A four point scale will be used for all ratings:

- Outstanding
- Good
- Requires improvement
- Inadequate

Ratings will always take account of all sources of information:

- Intelligent monitoring tool
- Information provided by Trust
- Other data sources
- Findings from site visits:
  - Direct observations
  - Staff focus groups
  - Patient and public listening events
  - Interviews with key people

Ratings: Approach (2)

Bottom up approach: Rate each of the 8 core services on each of the five key questions (safe, effective, caring, responsive, well led).

Then rate the Trust as a whole on the five key questions, including an overall assessment of well led at Trust level.

Define a final overall rating.

Note: Where Trusts provide separate services (e.g. A&E or maternity) on different sites we will attempt to rate these separately.
PRESENTATION 3

The new approach and equality

The new approach enables us to look at issues of equality more rigorously than before, through:

- Better pre-inspection data gathering (e.g. patient surveys and staff surveys)
- Increased emphasis on gathering the views of patients, families and friends (listening events)
- Larger inspection teams, covering equality topics in more depth
- Ratings: Look for good as well as poor practice
- The ‘well-led’ domain, particularly looking at the culture of an organisation
- Specific focus on care for groups at higher risk of poor care (e.g. people living with dementia, people with learning disabilities)

What we still need to do to promote equality

- Better analysis of surveys by patient/staff group
- Better acquisition / assessment of qualitative information
- Talking to specific equality groups between inspections
- More training for our inspection teams on equality
- Evaluation and learning from our new approach
- Publicising what we find both on individual inspections and across sectors

Summary

- The new approach represents a radical change for CQC
- Initial feedback has been positive, but we know that there is considerable scope for further improvement
- We are committed to putting patients first – and to being a learning organisation

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Dartford and Gravesham NHS Trust

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<th>Service</th>
<th>Overall</th>
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Friday 6 June 2014
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www.nhsbmenetwork.org.uk
Ruth Passman
Deputy Director Equality and Health Inequalities
NHS England

Ruth Passman is the National Deputy Director for Equality and Health Inequalities for NHS England. Ruth has enjoyed a diverse portfolio career spanning the voluntary, academic and public sectors. In the field of health and regeneration, Ruth has acted at Directorial and Chief Executive Level, establishing and leading organisations and renewal programmes.

She has worked in the Department of Health and across government on the wider determinants of health agenda as Senior Health Policy Adviser/ Public Health Specialist and covered all major policy portfolios including local area agreements, social value and sustainability, human rights in healthcare, end of life healthcare, ethnicity and health, and recovery.
PRESENTATION 4

Ethnic Inequalities in Health: A View from NHS England

Ruth Passman, Natasha Peniston and Bernard Spencer
June 2014

Beyond rights to the ethical case to promote equality and tackle health inequalities

The NHS is a universal service for the people of England, and NHS England is under specific legal duties in relation to tackling health inequalities and advancing equality.

The NHS Constitution-Rights, principles, ambitions and values

- The NHS provides a comprehensive service available to all irrespective of race.
- Everyone counts. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind.
- You have the right not to be unequally discriminated against in the provision of NHS services including on grounds of race.

Health Inequalities: Legal Duties under the Health and Social Care Act 2012

- The Act enshrines explicit duties on NHS England and clinical commissioning groups (CCGs) to have regard to the need to reduce inequalities with regard to access to, experience of and outcomes from healthcare services.
- Further duties require NHS England and CCGs to integrate both healthcare and other services where this may reduce health inequalities.
- NHS England has a duty to annually assess each CCG’s performance with regard to these duties.

The NHS Outcomes Framework

Transforming how well the NHS performs by:

- Enhancing quality of life for people with long-term conditions.
  - Black African Caribbean men are 30% more likely to die from prostate cancer than white men (BME Cancer Communities, 2013).
- Helping people to recover from episodes of ill health or following injury.
  - 50% of all men and 56% of all women aged 65 and over living in England and Wales reported a limiting long-term illness in 2011 but more illness is reported by Bangladeshis (69% and 76%) and Pakistanis (64% and 77%) men and women.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.
  - 54% of asylum seekers and refugees are turned away from GP practices.

Beyond rights to the ethical case to promote equality and tackle health inequalities

3

The NHS Outcomes Framework

Transforming how well the NHS performs by:

- Preventing people from dying prematurely.
  - Evidence suggests that the differences in life expectancy tell a story about the cumulative impact of inequalities experienced by different groups.
  - Data regarding causes of early death - taking into account a responsibility to safeguard the lives of people from different groups equally.
  - It is estimated that 15-20% of the life expectancy gap can be directly influenced by healthcare interventions.
- Ensuring people have a positive experience of care.
  - GP Patient Survey results in 2009/10 the percentage of patients who were very satisfied with the care from their GP or health centre was 60% and 56% for Irish and British ethnicities respectively, compared with Chinese (27%), Bangladeshis (28%) and Pakistanis (29%).
  - GP Patient Survey results in 2012/13 show significant variation by ethnicity in patient confidence and trust in their GP; British (67%), compared with Chinese (42%), and Bangladeshis (52%).

Health Inequalities: Legal Duties under the Health and Social Care Act 2012

- The White Gypsy or Irish Traveller group, identified for the first time in the 2011 Census, has particularly poor health.
  - Both men and women have twice the White British rates of limiting long-term illness, and at each age they are the group most likely to be ill.
- Religion

Muslims, Sikhs and Caribbean Christians have worse health than white Christians e.g. self assessed health, limiting longstanding illness, diabetes and waist/hip ratios.

(Kartew and Nazroo, 2009)

Religion

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PRESENTATION 4

NHS England Strategic Priorities – Context

Set within the context of the Health and Social Care Act 2012, and the Equality Act 2010

Reflective of the NHS Constitution values and pledges

The 9 strategic priorities reflect the different roles of NHS England:

- NHS England’s role as a system leader
- NHS England as a commissioner
- NHS England as an employer of over 6,000 staff, ‘Equality, Diversity and Inclusion in the Workplace Strategy’

NHS England Strategic Priorities – as system leader

- Re-establish the Equality Diversity Council
- Launch the Equality Delivery System (EDS) 2
- Expand and improve data available to measure equality and health inequalities
- NHS Leadership Academy, working with Health Education England to develop and implement values-based recruitment across the NHS, focused upon the identification and management of talent. Thus aspiring to create an NHS workforce and leadership that is reflective of the communities that we serve, and creating working environments that are free from discrimination.

The Equality Diversity Council

The Equality Diversity Council provides visible leadership on equality and health inequalities issues across the NHS. Its purpose is to shape the future of the NHS from an equality, health inequalities and human rights perspective and to improve the access, experiences, health outcomes and quality of care for all who use and deliver health and care services.

Chaired by the CEO of NHS England with diverse membership from system leaders, NHS, patient representation, staff and staff side, local authority, academia, think tanks, community and voluntary sector.

Leadership Diversity

- The lack of diversity in boardrooms needs addressing as a priority in order to bring the best resources to leadership, culture, innovation, ethics and behaviour.
- In 2012, just 1% of NHS chief executives came from a BME background, whilst there was just one non-white face in the 2012 Health Service Journal list of the one hundred most influential people in healthcare.
- A snapshot of CCG leadership on governing bodies shows that 12% are from BME, and 37% are women. However this masks significant variation, with over 40 CCGs without any female GP leadership on their governing bodies.

BME Staff engagement and satisfaction

- An established link between the treatment of BME staff and the care patients receive
  - “Research suggests that the experience of black and minority ethnic (BME) NHS staff is a good barometer of the climate of respect and care for all within the NHS
  - “Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received” NHS Staff Survey and Related Data West, M et al (2012)

NHS Staff survey data and ethnicity

- The 2011 NHS Staff Survey found that harassment, bullying or abuse was experienced more by BME staff (25% rising to 29%) and for mixed race staff in acute trusts than by white British staff (13%) NHSE Health and Wellbeing, Benefit Evaluation Model, 2006
- The 2012 NHS Staff Survey found bullying and harassment (including that linked to a ‘protected characteristic’ in equality law) from colleagues and managers was reported by 24% of staff, a much higher level than that reported outside the NHS

Equity Delivery System for the NHS

Its aim - to help the NHS review and improve its equality performance and to help the NHS deliver on the public sector Equality Duty

Organisations analyse and grade their equality performance against 18 EDS outcomes grouped into 4 EDS goals

- Better health outcomes for all
- Improved patient access and experience
- Representative and supportive workforce
- Inclusive leadership

Next steps for the EDS

NHS England has:
- Agreed shared governance with Equality and Diversity Council
- Continued to play in the NTDA, CQC, HEE, Monitor, community voluntary sector, and NHS colleagues

Developments underway:
- Embedding within key policy levers
- Equality & health inequalities monitoring / disaggregation
- Launch the Equality Delivery System (EDS 2)
- System alignment
- Embedding equality and tackling health inequalities within the key policy levers for the NHS
- Leadership and workforce
  - Senior BME representation / Values based recruitment
- Data measurement
  - Equality & health inequalities monitoring / disaggregation

EDC work priorities

1. Equality Delivery System – EDS2
   - Supporting implementation and effective use across NHS

2. System alignment
   - Embedding equality and tackling health inequalities within the key policy levers for the NHS

3. Leadership and workforce
   - Senior BME representation / Values based recruitment

4. Data measurement
   - Equality & health inequalities monitoring / disaggregation

5. Communications

...Workforce representation

- Link between representative workforce and better health outcomes for patients is well-known
- Under-representation of BME staff at senior and leadership levels within NHS organisations exists
- This is a priority area for the EDC going forward – Simon Stevens speech at Kings Fund Leadership event in May
- EDC led ‘expert group’ to produce strategic approach for July EDC meeting
- Commitment to make a meaningful and sustainable difference on this issue

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System-data to measure equality and health inequalities

- Expand and improve data available to measure equality and health inequalities
- A National Equality and Health Inequalities data group is being established to determine data collection, monitoring and dissemination requirements and drive delivery within NHS England and the wider system.

NHS England AGM: Health Inequalities and Equality messages

The need to use evidence to inform decision making. This included the need for clinicians and managers to truly understand how services are experienced by different people as well as for better disaggregation and interpretation of quantitative data by protected characteristics and geography.

Participants identified that staff attitudes are strongly linked to patient experience and outcomes. Cultural transformation is needed and can only be achieved by staff working in collaboration with ‘experts by experience’, NHS Champions and patients.

NHS England Strategic Priorities: Five relating to the exercise of its own functions

- Embed the criterion of reducing inequalities in health outcomes in resource allocation methodology.
- Incorporate and prioritise improvements in primary care towards areas and groups of people, including homeless people, with worst health outcomes.
- Embed equality and tackling health inequalities in the NHS England, CCG and area team assurance regimes and development support.
- Remove all existing specialised commissioning derogations within 18 months.
- Ensure that the NHS England programme for promoting parity of esteem addresses the equality and health inequality issues for people with mental health problems.

Ethnic inequalities- recent work

- Inclusion Health reports, guidance, models and protocols.
- National group established – consistent quality standards for translation and interpreting.
- Primary care access/GP registration issues for asylum seekers and refugees – primary care oversight group.
- EOLC - preferences for people with protected characteristics.
- Parliamentary work on Diabetes in BME Communities: Raising awareness and improving outcomes.

Natasha Peniston

Lived Experience Champion for the NHS

- Lived Experience advising group member for the Information Sharing to Tackle Violence initiative supporting the development of the national ISTV communications strategy from a community/lived experience perspective.
- Trained Mindfulness teacher delivering to NHS staff and support to prisoners (Mindfulness from the Inside).
- Honorary staff member at the University of Manchester for her work in preventing suicide in prisons and improving prison healthcare.

Leadership Messages

- Inclusive leadership in the NHS (Kings Fund Annual Summit).
- Mobilising for the next stage of the NHS journey (NHS Confed).
- Different answers for diverse communities and local flexibility to better match the needs of the people we serve.
- A creative system re-design with solutions driven by the energy of NHS staff, patients and partners.
- Using data to drive transparency, quality, improvement.
- Health as a social movement, working with communities, volunteers and with patients in shaping their health and care.

Why Race Matters to Health

- Health is affected by income, levels of education, quality of housing and access to services and assets.
- Experiences of discrimination and can affect health in multiple ways including socioeconomic and educational attainment.
- Discrimination can lead to reduced access to desirable goods and services.
- Exposure to adversity and internalized racism (acceptance of society’s negative characterization) can adversely affect health.
- Place Matters: ‘Housing Segregation’ determines quality of education and life chances, including socioeconomic and educational attainment.
- Housing conditions, can constrain the practice of health behaviors and encourage unhealthy ones and can adversely affect access to high-quality medical care. (Professor Williams, Unequal Impacts).

Shark differences in employment levels for BME women compared to white women, who face particular ‘in to work’ barriers

- BAME women already face multiple disadvantages in our society. They’re more likely to live in poverty, rely on working age benefits and tax credits for a higher proportion of their income, and they’re disproportionately represented in low paid employment.
- Unemployment among black and minority ethnic women in Coventry increased by nearly 75% between 2009 and 2013, compared to 30.5% for white women.
- Jobseekers who ‘refuse to learn English’ can be penalised with benefit sanctions yet face cuts to ESOL and childcare provision. These same women are finding it harder to access health and other public services because translation provision has been cut.
**Race-related impacts: Criminal record as a Barrier to Employment and wellbeing**

Black young adults are four times as likely as white young adults to be in prison. Possession of a criminal record is a significant barrier to employment, likely to leave young people economically disadvantaged and to increase the chances of re-offending. Employer discrimination, the low levels of skills and qualifications amongst offenders, their poor self-esteem, and behavioural and health problems are all factors that can reduce chances of securing a job.

**Tackling the social determinants of health negatively affecting BME communities**

- Improve housing and neighbourhood conditions
- Improve educational opportunities and outcomes
- Enhance access to additional income, employment opportunities, assets and resources
- Adopt race-specific solutions to the race-related health issues

Reduce violence and incarceration impacting disproportionately on BME communities

(Professor Williams. 'Unequal Treatment')

**Evidence**

The Cardiff Violence Prevention Programme (CVPP) found:
- A decrease of 35% in numbers of assault patients seeking A&E treatment
- Lower levels of violence in Cardiff compared to other cities
- Earlier and more effective intervention to assaults by the police
- An 82:1 cost-benefit ratio over 5 years.

**ISTV Information Standard**

- 40% of A&E collect anonymous data on attendances from violent incidents
- Significant variation in data collected and methods used
- Information Standard ensures data is collected and shared (with Crime and reduction Partnerships) in consistent, safe and legal manner

**Case Study 1**

Bernard Spencer

- Born in Barbados - 62 years
- Came to London aged 8
- 38 years as auto electrician/ HGV Driver.
- Serious RTA in 2002 and proposed double amputation.
- Multiple soft tissue, skin and muscle transplants and orthopaedic reconstructions.
- Sports Therapy Masseur and Royal Society of Public Health qualified 2012
- Keen to work in the NHS!!!

**Case Study 2**

Rose Spencer

- Born in Barbados - 83 years
- Came to London aged 25
- 50 years in ‘ Lyons’ packing work/administrative work
- High blood pressure managed since 60s/ Diabetes
- Active and healthy until death of close relative in 2013

**Healthcare Challenges:**

- Stroke at age 83
- ‘Mismatch’ of communication / healthcare style with healthcare providers
- Misdiagnoses, prescribing errors inconsistent access to rehabilitation, physiotherapy and healthcare practitioners.

**Unemployment may itself increase the chances of criminality. Economic and social disadvantages have been identified as widely occurring features in the background of many young adult offenders and imprisonment can result in increased risks of suicide and self-harm, by up to six times.**

PRESENTATION 5
Why the NHS needs to be Cured

Julie Bailey
Cure the NHS

Julie Bailey is founder of Cure the NHS, a group established in December 2007 after the death of her Mother in Mid Staffs Foundation Trust hospital. The group successfully campaigned for a public inquiry into the failings at the hospital and the wider NHS.

The group offers support and advice to people throughout the country who have been harmed within the NHS. They are currently trying for charitable status to continue with the work.

Julie speaks to a wide range of audiences and has been working with leaders from England, Scotland and Wales. Her book “From Ward to Whitehall—the disaster of Mid Staffs” captures the struggle she had to be heard to help to expose systemic failings within the NHS.

Julie was awarded a CBE in the New Years Honours list for her services to older people. The group continues to campaign for a safer NHS, zero harm, right first time, safe staffing levels and transparency of a hospital's performance.
My first impression was of a chaotic atmosphere. Staff appeared stressed and not in control. They told me that they were six senior staff down, with one suspended and one on sick leave. The agency staff nurse had not appeared. There were patients calling out, one stuck in bed with bed rails and one lady said to me “I am in Hell.”

J. Andrews, M. Butler. Trusted to Care. 6th May 2014. 3.2. pg 10
Values Based Commissioning

Emeritus Professor Christopher Heginbotham
Emeritus Professor of Mental Health Policy and Management
University of Central Lancashire

Chris Heginbotham is Emeritus Professor of Mental Health Policy and Management at the University of Central Lancashire, and holds a Visiting Professorship at the University of Cumbria where he works on telehealth and rural healthcare, in particular suicide prevention. He was Chief Executive of Mind, the National Association for Mental Health, for much of the 1980s, when he represented the World Federation for Mental Health at the UN Commission on Human Rights in Geneva; and he has held a number of Chief Executive positions within the NHS, including being Chief Executive at different times of two NHS Trusts and two health authorities, one of which was the Mental Health Act Commission. One of his principal responsibilities at the Commission was to establish and implement the Census ‘Count me in’ which considered the way mental health services are provided to Black and minority ethnic communities and service users.

Following his work at the MHAC he joined the University of Central Lancashire where he set up the Institute for Philosophy, Diversity and Mental Health. In the 1980s and early 1990s he held non-executive positions with various health authorities, including appointment as Chair of Redbridge and Waltham Forest FHSA. He is presently a Non-Executive Director of Lancashire Care NHS Foundation Trust and a Board member of the Global Health Equity Foundation, Geneva, where he leads on international health equity research and provides consultancy on health and wellbeing strategies with a particular focus on social determinants of physical and mental health. He is the author of five books of which the most recent are Values Based Commissioning of Health and Social Care (CUP, 2012) and Commissioning Health and Wellbeing (co-written with Dr. Karen Newbigging) (Sage, 2013).
VALUES-BASED COMMISSIONING:
TOWARDS EQUITY FOR BLACK AND MINORITY ETHNIC COMMUNITIES WITHIN THE NHS

WHAT IS VALUES-BASED COMMISSIONING?

VALUES-BASED COMMISSIONING IS...

- A process that rests on three pillars*:
  - Patient, service user and carer views and values;
  - Clinical expertise and evidence;
  - Knowledge gained from scientific and other systematic approaches;
- which are used to achieve
  - a ‘full field’ perspective that balances values and evidence; and
  - a reasoned argument or discussion that accepts the views of all sides and communities as legitimate and seeks a compromise agreement in a spirit of open and respectful inquiry.

*See page 3 of the Joint Commissioning Panel commissioning guide: the JCP is a joint panel of the RCGP and RCPsych which has developed an important statement about using values-based practice in commissioning.

FACTS AND VALUES – FROM PROF BILL FULFORD

EVIDENCE-BASED PRACTICE (E-BP) AND VALUES-BASED PRACTICE (V-BP)

- We have heard a lot about E-BM or E-BP over the last 10 years but the corresponding values base has not until recently been discussed widely - but things are changing.
- E-BP and V-BP are two sides of the same coin
- Many ‘facts’ are value laden – there is little in health and social care that is ‘evidence’ without values, or ‘values’ without evidence (e.g. QALYs)

VALUES-BASED PRACTICE

- Values-basing is the practice of recognising and acting on the differing values held by all those engaged in making health and social care decisions…..whether service users or professional staff..
VALUES-BASED PRACTICE

- Values-basing is the practice of recognising and acting on the differing values held by all those engaged in making health and social care decisions.
- In order to plan and implement health and social care that is:
  - culturally relevant and appropriate,
  - clinically and economically effective,
  - culturally relevant and appropriate,
  - clinically and economically effective,
  - addresses need in a way that reflects the values of those using and providing care.

VALUES-BASED PRACTICE PROVIDES SKILLS FOR WORKING WITH VALUES DIFFERENCES

- Health and social care is values-driven as well as evidence-driven. It is now expected that the evidence-base should be made explicit, but the corresponding values-base has, by and large, been left implicit.
- Values-based practice is effective not because it allows everyone’s expectations to be satisfied but because it provides a process that is seen to be transparent, fair and balanced.
- Values-based practice complements evidence-based practice by providing skills and support processes for working with differences of values.

VALUES-BASED PRACTICE IS TRANSPARENT, FAIR AND BALANCED

- Current policy priorities driving the need for values-based as well as evidence-based practice include:
  - Primary care clinically-led commissioning (in which commissioners engage with widely divergent cultural values);
  - Values-based clinical provision;
  - Health equity requirements; and
  - The personalisation of services (the basis of which is individually defined needs).

VALUES-BASED PRACTICE...

- Starts by identifying and making explicit the often very diverse values of all those involved whether as commissioners, as providers or as users of services;
- Maps this diversity within a clear framework that includes not only ethical values but also needs, wishes, aspirations, strengths and resources;
- Draws on the diversity of values thus identified as a resource for balanced decision making within the context defined by the relevant framework;
- And engages with an on-going process of...
VALUES-BASED PRACTICE...

- Starts by identifying and making explicit the various common values of all those involved whether as commissioners, as providers or as users of services.
- Maps this diversity within a clear framework that includes not only values but also needs, wishes, aspirations, strengths and resources.
- Volves the diversity of values, thus identified, as a resource for making balanced decisions within the context defined by the relevant framework.
- And engages in an ongoing process of evidence-based review.

Diversity demands full recognition of the needs of BME communities; Recognition demands knowledge; Knowledge requires engagement; Engagement demands respect.

V-BP REQUIRES EXPLICIT REASONED ARGUMENT

- A helpful starting point for values-based practice is Hume’s principle that you cannot derive an ‘ought’ from an ‘is’. No matter how many descriptive facts (evidence) are established about a situation or action nothing follows about its rightness or wrongness, or about what ought or ought not to be done, without the addition of some evaluative premise that can be applied to these facts.

OBJECTIVE VALUE

- Value judgments are not merely expressions of feeling or preference: they aim to say what is really good or bad, right or wrong, just or unjust, in virtue of the objective principles and reasons that can be applied to the choices in front of us.

VALUES-BASED COMMISSIONING HAS THREE LEGS

- Evidence of what works and in which context;
- Values of all those involved but especially service users, carers and communities;
- Clinical expertise putting the evidence into practice.

THEREFORE, VALUES-BASED COMMISSIONING SETS AND ACHIEVES OUTCOME OBJECTIVES DESIRED BY PATIENTS AND SERVICE USERS.
THE ‘SO-WHAT’ QUESTION

- Values are essential. Most health care is based on values even those aspects that we think are objective (e.g. cost-utility arguments)
- If we are to offer acceptable and equitable patient/service user centred care it will depend on a balance of values and evidence
- Patient and public involvement (PPI) demands a rigorous process, at every turn, to enshrine and learn from the values of patients and service users

TEN PRINCIPLES OF VALUES-BASED PRACTICE IN MENTAL HEALTH COMMISSIONING

They are:
- Four principles of clinical skills
- Two principles of relationships
- Three principles of science and values together
- A final important principle: ‘dissensus’.

Values-based practice demonstrates that, as so often, it is good process that makes for good decisions.

See Fulford, Peile and Carroll (2012)

BUT HOW DO WE GO ABOUT OBTAINING ‘VALUES’?

- We need thick rather than thin systems
- Thin systems are just that – minimal attention to values, getting away with the least substantial process, perhaps token involvement of service users with little real opportunity to change anything, and little attention to what the values really tell us
- Thick systems include a genuine attempt to understand service users view and to make the necessary adjustment to procedures and learning, values and equity.

DISSENSUS

- The tenth principle is ‘dissensus’: ‘agreeing to disagree’, an outcome that is peculiar to values based practice.
- Undertaking values-based commissioning requires that clinical commissioners (GPs, nurses, hospital doctor and nurse, etc.), patients and service users and their families, and the community in various guises, are all involved in the process. But at the end of the day not all values can be brought into the equation. Some values may be held over, not discarded but retained to be balanced by another subject on another day. There is no harm in this, if everyone accepts the process, which must of course be seen to be fair, open, transparent and honest.

WE NEED A PROCESS OF ‘MORE-THAN-CONSULTATION’, ENGAGING MEANINGFULLY, LISTENING AND IMPLEMENTING WHAT WE FIND, AT ALL STAGES

- Simple community values that are engaged on a generic basis
- A generic approach accepting national guidelines
- Complex community values demanding a detailed approach to all relevant (and diverse) groups in the community
- A complex multi-faceted system for drawing out information democratically and ensuring implementation
PRESENTATION 6

SERVICE USER AND COMMISSIONER
VALUES

PROPOSED NHS ASSEMBLY USES THE
IDEA OF ‘SPACES’

- Discovery space
- Gather space
- Assembly space

THREE SPACES WORKING
TOGETHER

VALUES-BASED PRACTICE PLACES
AN EMPHASIS ON OUTCOMES

Regular and frequent engagement leads to improved compliance, better more focused services, and lower overall cost

NEED TO BALANCE COST WITH THE IMPORTANCE OF FULLY ENGAGED SERVICE USERS

FOR EXAMPLE, VALUES BASED COMMISSIONING DRIVES OUTCOME LED COMMISSIONING

CONCLUSION

PROPOSED NHS ASSEMBLY USES THE IDEA OF ‘SPACES’

- Discovery space
- Gather space
- Assembly space

THREE SPACES WORKING TOGETHER

VALUES-BASED PRACTICE PLACES AN EMPHASIS ON OUTCOMES

Whether in health or social care or in research. Our values are critical to the research enterprise, and ensure it is done ethically and with due concern for those being studied.

CONCLUSION
PRESENTATION 6

- Values-based Practice helps to achieve a balanced approach to equity in commissioning health care;
- Values and evidence are two sides of the same coin;
- Only by understanding the values of communities from within those communities will it be possible to achieve health care that is meaningful for the community served.

SUSTAINABLE COMMUNITIES
- If we want integrated diverse communities and sustainable equitable commissioning for those communities then we must have sustainable values-based agreements on all aspects of health care;
- We must achieve equity for all service users regardless of age, deprivation/social class, disability, ethnicity, gender, religion or faith, sexual orientation or any other characteristic over which people have no direct control.

SOME RESOURCES: VALUES-BASED PRACTICE
- Fulford, Peile and Carroll (2012) Essential Values-Based Practice.
- Thistlethwaite (2013) Values-Based Inter-professional Collaborative Practice.
- Values-based commissioning in mental health. Published by the Joint Commissioning Panel, RCGP/RCPsych

THANK YOU

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- +44-7768488444

THUS WE NEED VALUES AS WELL AS EVIDENCE
- This demands
  - The need to understand values as well as evidence;
  - A recognition of the wide diversity of values;
  - The importance of discussing values openly and respectfully.
  - By engaging patients, service users and carers fully in making these decisions it will be possible to move towards equitable health and social care in which all BME communities are treated fairly.

CHALLENGES. GETTING VALUES...
- means a rigorous programme of engagement - time spent early on will save arguments later;
- requires a continuing programme that reflects and checks back regularly;
- is serious about involving all segments of the community regardless of age, disability, deprivation, ethnicity, gender, sexual orientation;
- takes as axiomatic that service users from all parts of the community will be engaged as experts by experience;
- develops genuinely personalised health and social care.

THEREFORE WE NEED VALUES AS WELL AS EVIDENCE
Question & Answer Session

1. Which organisation do you work for?

<table>
<thead>
<tr>
<th>Organisation</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust</td>
<td>39%</td>
</tr>
<tr>
<td>Ambulance Trust</td>
<td>2%</td>
</tr>
<tr>
<td>Clinical Commissioning Group (CCG)</td>
<td>7%</td>
</tr>
<tr>
<td>Local Authority</td>
<td>2%</td>
</tr>
<tr>
<td>Mental Health Trust</td>
<td>4%</td>
</tr>
<tr>
<td>Public Health</td>
<td>12%</td>
</tr>
<tr>
<td>Third Sector Organisation</td>
<td>11%</td>
</tr>
<tr>
<td>None of these</td>
<td>23%</td>
</tr>
</tbody>
</table>

2. In what capacity are you attending the conference today?

<table>
<thead>
<tr>
<th>Capacity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee of an organisation</td>
<td>75%</td>
</tr>
<tr>
<td>A BME user of NHS services</td>
<td>20%</td>
</tr>
<tr>
<td>A non-BME user of NHS services</td>
<td>5%</td>
</tr>
</tbody>
</table>

3. Which category best describes your occupation?

<table>
<thead>
<tr>
<th>Category</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration and Clerical</td>
<td>7%</td>
</tr>
<tr>
<td>Doctor</td>
<td>5%</td>
</tr>
<tr>
<td>HR Professional</td>
<td>6%</td>
</tr>
<tr>
<td>Manager</td>
<td>30%</td>
</tr>
<tr>
<td>Nurse</td>
<td>22%</td>
</tr>
<tr>
<td>Scientist</td>
<td>8%</td>
</tr>
<tr>
<td>Volunteer</td>
<td>18%</td>
</tr>
<tr>
<td>None of these</td>
<td>39%</td>
</tr>
</tbody>
</table>
Question & Answer Session

4. Is BME Equity in the NHS / Health Sector a reality today?

1. Yes 11%
2. No 76%
3. Don’t Know 13%

5. What is the number one barrier for achieving race equality in the NHS?

1. Institutional and individual racism 38%
2. Lack of cultural competency 8%
3. Lack of leadership 13%
4. Lack of diversity on Trust Boards and senior management 24%
5. Lack of commitment 15%
6. None of these 1%

6. Do you believe that the current NHS strategy will/can deliver race equality?

1. Yes 11%
2. No 75%
3. Don’t Know 13%
Question & Answer Session

7. Does the NHS need a new strategy to deliver BME equity?

1. Yes  2. No  3. Don't Know
   1  88%  2  10%  3  3%

8. To what extent do you believe the leaders of the NHS/health sector are serious about addressing BME inequalities?

1. 0%  2. 25%  3. 50%  4. 75%  5. 100%
   1  38%  2  45%  3  11%  4  5%  5  2%

9. BME users of services need to be empowered to achieve true partnership working in the NHS/Health Sector. Do you agree?

1. Yes  2. No  3. Don't Know
   1  98%  2  1%  3  1%

10. Will more diverse leadership in the NHS contribute greatly to achieving BME equity in the NHS/Health sector?

1. Yes  2. No  3. Don't Know
   1  93%  2  4%  3  4%
Question & Answer Session

11. Should the Equality Delivery System (EDS2) be scrapped given the evidence clearly shows it is not working?

1. Yes
2. No
3. Don't Know

- Yes: 57%
- No: 31%
- Don't Know: 12%

12. Do you believe the Care Quality Commission needs to do more to address the institutional racism in the NHS given the impact on patient safety?

1. Yes
2. No
3. Don't Know

- Yes: 98%
- No: 2%
- Don't Know: 1%

13. In the current climate should the NHS/health sector adopt a positive action to address the institutional racism that exist?

1. Yes
2. No
3. Don't Know

- Yes: 95%
- No: 3%
- Don't Know: 2%

14. Should positive action programmes be introduced that set targets for achieving diversity at all levels in the NHS?

1. Yes
2. No
3. Don't Know

- Yes: 94%
- No: 5%
- Don't Know: 2%
WORKSHOP 1

Addressing Ethnic Inequalities in Health

Dr Vivienne Lyfar-Cissé  
Chair  
NHS BME Network

In 1998 an independent inquiry into inequalities in health chaired by Sir Donald Acheson made three recommendations for reducing ethnic health inequalities notably:

1. Policies on reducing socioeconomic inequalities should consider the needs of BME groups
2. Services should be sensitive to the needs of BME groups and promote awareness of their health risks and
3. The needs of BME groups should be specifically considered in providing and planning healthcare

There have been numerous policy initiatives around inequalities in health over the years culminating in the Marmot Review, a strategic review of health inequalities in England post 2010. However, the fact remains most of these reviews including Marmot have failed to specifically address ethnic health inequalities. Furthermore, all the available evidence shows that inequalities based on ethnicity cannot simply be explained by socioeconomic position and that racial discrimination has a considerable adverse impact on health.

This workshop will explore what needs to be done to address the ethnic inequalities in health and how the NHS BME Network can influence the process.
NOTES FROM WORKSHOP 1

1 – How can the major barriers be overcome?

<table>
<thead>
<tr>
<th>NHS Trusts</th>
<th>Commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Health champions - training</td>
<td>- Embedding services within BME communities</td>
</tr>
<tr>
<td>- Use of interpreters</td>
<td>- Knowledge of communities</td>
</tr>
<tr>
<td>- Engagement at grass roots</td>
<td>- Commissioning funding priorities / community priorities – needs assessment</td>
</tr>
<tr>
<td>- Protection for “whistle-blowers” from e.g. intimidation or withdrawal of service or disciplinary action</td>
<td>- CCGs accountable – need to demonstrate this and show how we have done this</td>
</tr>
<tr>
<td>- Consequences for perpetrators of discrimination</td>
<td>- Investing in BME community development work so BME people are confident, supported and informed to engage</td>
</tr>
<tr>
<td>- Ensure BME people are represented at all levels. Deputy Directors’ level.</td>
<td>-</td>
</tr>
<tr>
<td>- Effective monitoring systems (not tick box)</td>
<td>-</td>
</tr>
<tr>
<td>- Equality Impact Assessments to be fed by public participation</td>
<td>-</td>
</tr>
<tr>
<td>- Name and shame discriminatory managers</td>
<td>-</td>
</tr>
<tr>
<td>- Data - collection, implementation</td>
<td>-</td>
</tr>
<tr>
<td>- Poor leadership - focus groups to be heard, accountability, - patient-led groups - staff groups - public involvement</td>
<td>-</td>
</tr>
<tr>
<td>- BME in positions of authority and influence</td>
<td>-</td>
</tr>
<tr>
<td>- Mandatory cultural awareness training on all NHS Boards</td>
<td>-</td>
</tr>
<tr>
<td>- Management made to take positive action e.g. access courses, leadership programmes, secondment into higher positions. Data collected on this to measure that happens</td>
<td>-</td>
</tr>
<tr>
<td>- Positive discrimination which is real, not tickbox, not the ‘token person’.</td>
<td>-</td>
</tr>
<tr>
<td>- Racism / general perception - professionals to be educated</td>
<td>-</td>
</tr>
</tbody>
</table>

Commissioners

- Embedding services within BME communities
- Knowledge of communities
- Commissioning funding priorities / community priorities – needs assessment
- CCGs accountable – need to demonstrate this and show how we have done this
- Investing in BME community development work so BME people are confident, supported and informed to engage
## NOTES FROM WORKSHOP 1

### 1 – How can the major barriers be overcome?

<table>
<thead>
<tr>
<th>BME Service Users / Communities</th>
<th>NHS BME Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Engagement at grass roots</td>
<td>- We have to ensure our voices are heard</td>
</tr>
<tr>
<td>- Ignorance – within community</td>
<td>- Supported BME Network for all organisations with BME staff</td>
</tr>
<tr>
<td>- Engagement of local people to understand the barriers</td>
<td>- More assertive, pro-active</td>
</tr>
<tr>
<td>- Language / communication – encourage learning of expressive language</td>
<td>- Form support networks</td>
</tr>
<tr>
<td>- Ignorance of patient rights – education by PALS and clinicians and carers</td>
<td>- Using BME Network to publicise</td>
</tr>
<tr>
<td>- Knowledge – knowing what is available to you</td>
<td>- Create safe places for BME to express how they really feel about their workplace</td>
</tr>
<tr>
<td>- Better integration into mainstream culture</td>
<td>- Expose institutional racism</td>
</tr>
<tr>
<td>- New emerging communities (Roma population)</td>
<td></td>
</tr>
<tr>
<td>- Ignorance on the part of the patients – raising awareness of health issues especially of minority groups within those communities</td>
<td></td>
</tr>
<tr>
<td>- Community Champions from all the different groups – advocates</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS Leadership Bodies (NHSE, PHE, DH etc)</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Representation on all tiers of NHS (at all levels)</td>
<td>- Accessibility - language, knowing what services are available, different ways to communicate i.e. deaf and blind</td>
</tr>
<tr>
<td>- Independent PALS</td>
<td>- Empower service users</td>
</tr>
<tr>
<td>- Promote BME people into positions of governance</td>
<td>- Cultural awareness – understanding</td>
</tr>
<tr>
<td></td>
<td>- General distrust – embedded belief / stereotypes. (Professionals / patients). Cultural taboos / cultural issues</td>
</tr>
</tbody>
</table>
## NOTES FROM WORKSHOP 1

### 2 – How can BME service users be best empowered?

<table>
<thead>
<tr>
<th>NHS Trusts</th>
<th>Commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Reverse commissioning</td>
<td></td>
</tr>
<tr>
<td>- Focus groups</td>
<td></td>
</tr>
<tr>
<td>- Where to go for support for e.g. family member – easy steps</td>
<td></td>
</tr>
<tr>
<td>- Health information in a language that people can understand</td>
<td></td>
</tr>
<tr>
<td>· other languages</td>
<td></td>
</tr>
<tr>
<td>· get rid of jargon</td>
<td></td>
</tr>
<tr>
<td>- Positive action</td>
<td></td>
</tr>
<tr>
<td>- Representation at all levels</td>
<td></td>
</tr>
<tr>
<td>- Patient led peer groups – training – liaison with staff</td>
<td></td>
</tr>
<tr>
<td>- Feedback – friends and family test</td>
<td></td>
</tr>
<tr>
<td>- Empowerment – user-participation e.g. design of service, involved in staff training, recruitment</td>
<td></td>
</tr>
<tr>
<td>- Trust Boards – get on them</td>
<td></td>
</tr>
<tr>
<td>- Create a meaningful dialogue with service users</td>
<td></td>
</tr>
<tr>
<td>- Appropriate representation on all user groups</td>
<td></td>
</tr>
<tr>
<td>- Engage community leaders</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BME Service Users / Communities</th>
<th>NHS BME Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Empowered – most effective and efficient ways to challenge the system</td>
<td></td>
</tr>
<tr>
<td>- Appoint community advocates</td>
<td></td>
</tr>
<tr>
<td>- Patients and carers to know their rights</td>
<td></td>
</tr>
<tr>
<td>- Patient and carer advocates investment (key)</td>
<td></td>
</tr>
<tr>
<td>- Financial support for involvement</td>
<td></td>
</tr>
<tr>
<td>- Armed with information</td>
<td></td>
</tr>
<tr>
<td>- “Choose” – understand care pathways</td>
<td></td>
</tr>
<tr>
<td>- Help those who cannot help themselves those communities</td>
<td></td>
</tr>
<tr>
<td>- Community Champions from all the different groups – advocates</td>
<td></td>
</tr>
<tr>
<td>- Service user forum – more BME representation and voice and training provided</td>
<td></td>
</tr>
<tr>
<td>- Roadshow</td>
<td></td>
</tr>
<tr>
<td>- Nationally recognised body to champion / campaign</td>
<td></td>
</tr>
<tr>
<td>- Help service users to positions of power</td>
<td></td>
</tr>
<tr>
<td>- Working in partnership with other authorities</td>
<td></td>
</tr>
</tbody>
</table>
## NOTES FROM WORKSHOP 1

<table>
<thead>
<tr>
<th>NHS Leadership Bodies (NHSE, PHE, DH etc)</th>
<th>Third Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Empowerment of 3rd sector</td>
<td>- Mentoring – e.g. mental health, long-term conditions, self-help groups</td>
</tr>
<tr>
<td>- Information standard – DoH</td>
<td>- Speak to BME workers in the Third Sector</td>
</tr>
<tr>
<td>- Contribute / be part of bodies that make policy decisions</td>
<td></td>
</tr>
<tr>
<td>- Health education</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- More members of public to understand realities behind health inequalities i.e. social inequalities, economic inequalities, race inequalities</td>
<td></td>
</tr>
</tbody>
</table>
### NOTES FROM WORKSHOP 1

#### 3 – How can the NHS BME Network influence this agenda?

<table>
<thead>
<tr>
<th>NHS Trusts</th>
<th>Commissioners</th>
</tr>
</thead>
</table>
| - NHS Trust by NHS Trust impact assessment  
- Patient care, participation  
- Board membership  
- Panel membership  
- Appointment / promotions at all levels  
- “Positive action based on merit” | - More BME involvement to speak more about their needs – service user forum reps  
- Local area advocate involved in development of JSNA |

<table>
<thead>
<tr>
<th>BME Service Users / Communities</th>
<th>NHS BME Network</th>
</tr>
</thead>
</table>
| - Reporting / raising concerns: don’t give up! Be a voice for the BME patients  
- Attending BME meetings regularly and be active participants  
- Local area advocate working with NHS BME Network representative  
- Use of social media  
- Complaints hotline  
- Whistle blowing hotline  
- Regional / national BME Network – more teeth  
- Annual State of BME Health survey / reports  
- Make it a priority  
- Strong leadership  
- We should be united  
- Share expertise to support us  
- Raise concerns  
- BME Network to be established in each department  
- Clear plan of actions and timescales  
- Defining mandatory outcome targets  
- Industrial actions / boycott  
- Work to rule  
- Support local networks to develop through regional events (annually) targeted | - Funding? – ring fenced  
- Position at table at NHS England, CQC, Monitor etc.  
- Better publicity from BME Network or encouraging NHS England to say what they are doing |
NOTES FROM WORKSHOP 1

3 – How can the NHS BME Network influence this agenda?

<table>
<thead>
<tr>
<th>BME Service Users / Communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Raising awareness of issues through different media</td>
</tr>
<tr>
<td>- Don’t wait to be asked to influence, be pro-active</td>
</tr>
<tr>
<td>- Hold people accountable – come back next year and show us what you have done</td>
</tr>
<tr>
<td>- BME Network needs to be more visible</td>
</tr>
</tbody>
</table>
WORKSHOP 2

Improving BME Patient Experience in Mental Health

Chair - Becky Aldridge
CEO
Dorset Mental Health Forum

The Government’s Mental Health strategy, No Health Without Mental Health, published in 2011 aims to ensure that:

1. Mental Health must have equal priority with physical health
2. Discrimination associated with mental health problems must end
3. Everyone that needs mental health care should get the right support at the right time
4. Premature mortality of people with mental health is addressed
5. More is done to prevent mental ill health and promote mental well being

It is a fact that the inequalities in the mental health system continues for BME people to be an unresolved tragedy. For example black people are consistently over-represented in the most serious end of the mental health system and consistently under-represented in the mild and moderate treatment areas. The Delivering Race Equality (DRE) in Mental Health Care (2005) made recommendations about the delivery of mental healthcare to BME communities in particular but very little by way of improvement has been achieved.

Closing the Gap-Priorities for Essential Change in Mental Health aims to bridge the gap between the government's long-term ambition and short-term actions. The document identifies twenty five priorities where the public can expect to see and experience the fastest changes for example how to ensure the mental health services that are commissioned meet the needs of all communities and tackling inequalities around access to mental health services such as access to psychological therapies by BME communities.

This workshop will explore what needs to be done to improve the BME patient experience in mental health and how the NHS BME Network can influence the process.
### NOTES FROM WORKSHOP 2

**Summary notes**

<table>
<thead>
<tr>
<th>NHS Trusts</th>
<th>NHS BME Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Local services specialising within cultures / cultural context – services designed around communities and cultures</td>
<td>- Empower people – rights based approaches</td>
</tr>
<tr>
<td>- Enabling people to be heard in meaningful way – systems and structures including formal ways</td>
<td>- Empower BME community</td>
</tr>
<tr>
<td>- Structures for meaningful engagement</td>
<td>- Push fact that it’s time to act – talking done, data collected</td>
</tr>
<tr>
<td>- Training and raising awareness of cultures</td>
<td>- Use BME Network to help people and organisations to overcome barriers and attitudes</td>
</tr>
<tr>
<td>- Access to local community groups</td>
<td>- BME Network identity. Why not use logo? Why are / is the NHS pushing us away? NHS BME Network be driving force – walk the walk – case studies and narratives</td>
</tr>
<tr>
<td>- Collaboration</td>
<td>- Make sure changes happen. Hold NHS and other statutory agencies to account</td>
</tr>
<tr>
<td>- Services – more focus on personalised approach and care</td>
<td>- NHS BME Network – collective of organisations, people and communities</td>
</tr>
<tr>
<td>- Promotion / awareness – senior management and systems – lived experience at higher levels</td>
<td>- these need to take action and exercise voice now – apply pressure to strengthen communities and movement to make change happen</td>
</tr>
<tr>
<td>- Cultural groups represented at all levels</td>
<td>- Lobbying</td>
</tr>
<tr>
<td>- Patient as teacher. Listen to people.</td>
<td></td>
</tr>
<tr>
<td>Take their stories – essence of who people are.</td>
<td></td>
</tr>
<tr>
<td>- Cultural competencies priority with professionals in mainstream services</td>
<td></td>
</tr>
<tr>
<td>- Present and heard at all levels of organisation and service shaping, configuration, monitoring</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BME Service Users / Communities</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Fear into positive opportunity to learn</td>
<td>- Tackle from root cause. Develop shared understanding and sense of shared humanity – multi diverse</td>
</tr>
<tr>
<td>- Mechanisms for engaging in positive way – raising awareness in fun ways</td>
<td>- Change attitudes – co-production</td>
</tr>
<tr>
<td>- Lived experience expertise</td>
<td>- Work in partnership – equal partners – listened</td>
</tr>
<tr>
<td>- Champion to other people in system – modelling recovery / hope</td>
<td>- What is purpose of organisation – relevant to what they can do to effect change</td>
</tr>
<tr>
<td>- Listen to people who access services and staff</td>
<td></td>
</tr>
</tbody>
</table>

**NHS BME Network**

- Empower people – rights based approaches
- Empower BME community
- Push fact that it’s time to act – talking done, data collected
- Use BME Network to help people and organisations to overcome barriers and attitudes
- BME Network identity. Why not use logo? Why are / is the NHS pushing us away? NHS BME Network be driving force – walk the walk – case studies and narratives
- Make sure changes happen. Hold NHS and other statutory agencies to account
- NHS BME Network – collective of organisations, people and communities
- these need to take action and exercise voice now – apply pressure to strengthen communities and movement to make change happen
- Lobbying
NOTES FROM WORKSHOP 2

1 – What positive action is needed now to achieve equality of opportunity?

<table>
<thead>
<tr>
<th>NHS Trusts / Primary Care</th>
<th>Commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Legal rights concerning mental health care to be prioritised in staff training</td>
<td>- Community engagement</td>
</tr>
<tr>
<td>- More BME staff to be employed in Service User Involvement teams by NHS Trusts</td>
<td>- Financial support and communication</td>
</tr>
<tr>
<td>- All services e.g. access to OT, talking therapies etc. to be Equality Impact Assessed</td>
<td>- Accountability: monitoring of funding ensuring results</td>
</tr>
<tr>
<td>- Services to be individualised to meet BMEs diverse needs e.g. spiritual, cultural</td>
<td>- Ensuring BME mental health services remain open as funding is being taken</td>
</tr>
<tr>
<td>- There should not be discrimination from BME staff working in the NHS to people who use</td>
<td>away resulting in them closing</td>
</tr>
<tr>
<td>services who are also BME</td>
<td>- Specifically target CCG and develop census by BME England</td>
</tr>
<tr>
<td>- Person centred approach by professionals – listen to people</td>
<td>- Looking more broadly as BME community to facilitate closely involvements</td>
</tr>
<tr>
<td>- Training to be filtered to new staff within NHS (induction / not a tick box exercise)</td>
<td>of different BME groups so that we can identify common ground</td>
</tr>
<tr>
<td>- Action providing education, understanding our differentials</td>
<td>- If BME community is to have more engagement collect concise and accurate</td>
</tr>
<tr>
<td>- Use of extra services</td>
<td>information about the needs and appropriateness</td>
</tr>
<tr>
<td>- Increase education / training at all levels (internally)</td>
<td></td>
</tr>
<tr>
<td>- Provide information point of contact with BME communities</td>
<td></td>
</tr>
<tr>
<td>- Allow increase promotion in BME</td>
<td></td>
</tr>
<tr>
<td>BME Service Users / Communities</td>
<td>NHS BME Network</td>
</tr>
<tr>
<td>- Training / support to sit on CCGs, Health &amp; Wellbeing Boards, Trust Governor</td>
<td>- Measure outcomes “self reported”</td>
</tr>
<tr>
<td>- Finances to be available; resources too (office, phones, etc.)</td>
<td>- Recruit more BMEs, link in with more community groups</td>
</tr>
<tr>
<td></td>
<td>- Monitor / research</td>
</tr>
<tr>
<td></td>
<td>- Challenge discrimination and racism</td>
</tr>
</tbody>
</table>
# NOTES FROM WORKSHOP 2

1 – What positive action is needed now to achieve equality of opportunity?

<table>
<thead>
<tr>
<th>BME Service Users / Communities</th>
<th>NHS BME Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Respond to DoH consultations</td>
<td>- Confidence building, assertiveness training</td>
</tr>
<tr>
<td>- Full involvement of people with lived experience</td>
<td>- BME representation – BME voice</td>
</tr>
<tr>
<td>- Educating at school levels, external speakers i.e. service users presenting</td>
<td></td>
</tr>
<tr>
<td>- Utilise resources that are available, through promotion of events available in community</td>
<td></td>
</tr>
<tr>
<td>- BME community must work directly together in close knit unit looking at what issues sensitive subjects mean in common cultural language</td>
<td></td>
</tr>
<tr>
<td>- Raising awareness of issues through different media</td>
<td></td>
</tr>
<tr>
<td>- Don’t wait to be asked to influence, be pro-active</td>
<td></td>
</tr>
<tr>
<td>- Hold people accountable – come back next year and show us what you have done</td>
<td></td>
</tr>
<tr>
<td>- BME Network needs to be more visible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS Leadership Bodies (NHSE, PHE, DH etc)</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Need to bring the issue back to the original agenda – race equality e.g. DRE</td>
<td>- An understanding of shared humanity</td>
</tr>
<tr>
<td>- Need for continuity i.e. stop chopping and changing</td>
<td>- Action against prejudice, stereotypical views</td>
</tr>
<tr>
<td>- Listen to BME service users / carers / staff</td>
<td>- Co-production / shared decision making</td>
</tr>
<tr>
<td>- Need for implementation</td>
<td>- Collaboration (NHS and VSOs and community groups and faith leaders)</td>
</tr>
<tr>
<td>- Build a system that allows people to be heard</td>
<td>- Awareness at all levels</td>
</tr>
<tr>
<td>- Comparable studies e.g. BME and white groups needs</td>
<td>- Increase awareness external to organisations</td>
</tr>
<tr>
<td></td>
<td>- Inclusion of service users’ input</td>
</tr>
<tr>
<td></td>
<td>- Listen!</td>
</tr>
</tbody>
</table>
NOTES FROM WORKSHOP 2

1 – What positive action is needed now to achieve equality of opportunity?

<table>
<thead>
<tr>
<th>NHS Leadership Bodies (NHSE, PHE, DH etc)</th>
<th>All</th>
</tr>
</thead>
</table>
| - More frequent routine engagement as part of the inspection team with BME staff and people who use services  
- Uptake of involvement from Minister of Culture  
- Report on objectives and how these are being achieved / measured / monitored  
- NHS logo and support, officially | - More listening to those involved in services  
- Promote the wider cultural variations within the community, general hospitals, GPs, clinics |
**NOTES FROM WORKSHOP 2**

**2 – How can BME equity be achieved in NHS mental health services?**

<table>
<thead>
<tr>
<th>NHS Trusts / Primary Care</th>
<th>Commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Barriers to access / gate-keeping</td>
<td>- Funding BME orgs? / partners adequately</td>
</tr>
<tr>
<td>- Services to meet specific person’s needs</td>
<td></td>
</tr>
<tr>
<td>- Consultations / Focus groups / Research</td>
<td></td>
</tr>
<tr>
<td>- Parity between physical / mental health</td>
<td></td>
</tr>
<tr>
<td>- Empowering people with knowledge and information</td>
<td></td>
</tr>
<tr>
<td>- Cultural competencies from IAPT professional</td>
<td></td>
</tr>
<tr>
<td>- Turn the “BME issue” around from fear / unknown to positive opportunity to learn and develop</td>
<td></td>
</tr>
<tr>
<td>- Allow increase of promotions in professions of senior management</td>
<td></td>
</tr>
<tr>
<td>- More representative workforce, from groups that people can identify with</td>
<td></td>
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<tr>
<td>- Use more people with experience</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BME Service Users / Communities</th>
<th>NHS BME Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Capacity building in communities, to include religious places</td>
<td>- Cultural sensitivity</td>
</tr>
<tr>
<td>- Knowing rights – decision makers are held to account for their quality of care</td>
<td></td>
</tr>
<tr>
<td>- Traditions and beliefs</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS Leadership Bodies (NHSE, PHE, DH etc)</th>
<th>Third Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>- NHS to be more proactive in engaging with marginalised groups of people, e.g. African / Caribbean men, newly migrant communities – e.g. EU citizens, refugees</td>
<td>- Advocacy services that meet BME needs</td>
</tr>
<tr>
<td>- NHS to listen and act on our proposals, recommendations etc.</td>
<td>- Financial resources working with charity who do volunteering, who talk like us and understand us</td>
</tr>
<tr>
<td></td>
<td>- Advocacy support</td>
</tr>
</tbody>
</table>
## NOTES FROM WORKSHOP 2

2 – How can BME equity be achieved in NHS mental health services?

<table>
<thead>
<tr>
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<th>Third Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- Train faith leaders – better aware of</td>
<td></td>
</tr>
<tr>
<td>mental health</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- Joined up working by different</td>
<td></td>
</tr>
<tr>
<td>agencies e.g. ASB, police, mental</td>
<td></td>
</tr>
<tr>
<td>health</td>
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<tr>
<td>- Listen, use existing data / evidence</td>
<td></td>
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</tbody>
</table>
## NOTES FROM WORKSHOP 2

### 3 – What can you personally do, or as an organisation do, to bring about this change?

<table>
<thead>
<tr>
<th>NHS Trusts / Primary Care</th>
<th>Commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Representative workforce in all areas</td>
<td>- Adequate resources to meet gaps in service provision</td>
</tr>
<tr>
<td>- To be more person centred</td>
<td>- CCG, take up proactive action in BME, doctor referrals from patients</td>
</tr>
<tr>
<td>- Basic needs and details (individualised care)</td>
<td>- Widen campaigns / local services to increase involvement of BME groups / persons</td>
</tr>
<tr>
<td>- NHS Trusts can help setting up an infrastructure to enable engagement</td>
<td>Commissioners need to listen to patients and staff (and talk to staff)</td>
</tr>
<tr>
<td>- NHS Trusts can influence more awareness and training around BME and diversity issues</td>
<td></td>
</tr>
<tr>
<td>- Wider and larger platform for people from BME community to share personal testimony</td>
<td></td>
</tr>
<tr>
<td>- Issues of Equality and Diversity are written into every form of training (NHS)</td>
<td></td>
</tr>
<tr>
<td>- See people beyond their diagnosis</td>
<td></td>
</tr>
<tr>
<td>- Look at demographics – local needs – managers</td>
<td></td>
</tr>
<tr>
<td>- Supported outreach</td>
<td></td>
</tr>
<tr>
<td>- Linking with universities to ensure mental health courses to highlight the importance of service user involvement</td>
<td></td>
</tr>
<tr>
<td>- NHS to work closely with local BME voluntary groups</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BME Service Users / Communities</th>
<th>NHS BME Network / BME Staff as Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Be an “influencer”. Use personal story to challenge poor practice</td>
<td>- Challenge</td>
</tr>
<tr>
<td>- Get involved in staff recruitment and training: ensure fairness, equity and that best staff are recruited</td>
<td>- Work fairly to meet individual and organisations’ need</td>
</tr>
<tr>
<td>- Build capacity and resilience in BME communities</td>
<td>- Pressure group for change</td>
</tr>
<tr>
<td>- Give talks to schools, businesses, places where people get spiritual support / pastoral care, etc.</td>
<td>- Provide practical training (shared experience) to our white professional colleagues</td>
</tr>
<tr>
<td></td>
<td>- Raise awareness in conferences, focus group, regional and in community</td>
</tr>
<tr>
<td></td>
<td>- BME groups become more vocal</td>
</tr>
</tbody>
</table>
### NOTEST FROM WORKSHOP 2

**3 – What can you personally do, or as an organisation do, to bring about this change?**

<table>
<thead>
<tr>
<th>BME Service Users / Communities</th>
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</tr>
</thead>
</table>
| - Sit on different boards at all levels – make representation - make your voice heard - make a difference  
- More representation outside of GP, clinical service, get more BME persons to attend patient participation group to build capacity in community  
- Ask BME persons to attend community meeting specifically for mental health  
- Peer expertise  
- Community hold solutions | - Make conference attendance cost affordable to large scale community  
- BME equality champion (conduit) |

<table>
<thead>
<tr>
<th>NHS Leadership Bodies (NHSE, PHE, DH etc)</th>
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</tr>
</thead>
</table>
| - More research – on effects of mental health on BME service users - Train faith leaders – better aware of mental health | - Mentor people who use services and carers so they are confident and enabled to participate fully  
- VSOs and community groups can facilitate access to local BME communities and contribute to enable meaningful engagement e.g., MIND’s equality improvement work |

<table>
<thead>
<tr>
<th>All</th>
<th></th>
</tr>
</thead>
</table>
| - Be involved in changing attitudes of communities, media, etc. towards people who have mental health problems  
- Educate!  
- Sharing of expertise and experience |
WORKSHOP 3

Improving BME Staff Experience in the NHS

Chair - Rudi Page
Vice Chair
NHS BME Network

In 2008 the South East Coast BME Network Race Equality Review undertaken by Dr Vivienne Lyfar-Cissé found that BME staff were more likely to be disciplined, involved in grievances, involved in bullying or harassment disputes or pursue their case through employment tribunal. In addition the proportion of BME staff employed is, on average, less than half the proportion on the shortlist. At board level too, BME representation is neither a reflection of the workforce nor the diversity of the population.

More recently a race equality review of NHS Trusts in London undertaken by Roger Kline showed that BME representation on trust boards at 8% has fallen from a level of 9.6% in 2006. Similarly the proportion of chief executives and chairs from a BME background has decreased from 5.3% to 2.5% and two fifths of London’s NHS Trust Boards do not have a single BME board member despite the fact that 45% of the local population is from a BME background. It is evident that the positive action programmes aimed at BME staff to “breakthrough” have failed to deliver on the desired outcomes.

NHS Trusts are encouraged to use the Equality Delivery System (EDS) toolkit to deliver race equality, although not mandatory. Despite the many initiatives over the years the evidence clearly shows that BME staff continue to be discriminated against on the grounds of their race and as the beneficiaries we need to play a pivotal role in demanding action that will bring about real change.

Clearly, if the NHS cannot treat its own employees fairly it has no hope of providing ethnic minority patients with the service they have a right to receive. This workshop will explore what needs to be done to improve the BME staff experience in the NHS and how the NHS BME Network can drive that process.
NOTES FROM WORKSHOP 3

1 – What message do you want the NHS BME Network to give system leaders?

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</table>
| - Outcome focused that links to strategy  
  – what will CQC / NHS England do differently after today and how (when?)  
- CCGs, Trust have delivery of specific criteria re BME staff. Monitored for delivery of these  
- No-one wants to be treated differently but need equity of opportunity and education and experiences  
- Increase accountability for implementation of current actions which have already been identified, with consequences attached for inaction  
- Examine workforce data by ethnicity and compare qualifications and experiences to see if there are inequalities then act to reduce  
- Quota system  
- Senior management to represent the local community  
- Equal opportunity (new method to produce e.g. positive actions)  
- We need a voice from top to bottom or representation from all levels  
- EDS tool needs to be delivered - efficiently  
- Positive discrimination  
- Succession planning  
- Leaders must not be there for personal gain – it is all about patients and staff  
- Time to listen to BME staff and patients  
- All organisation must provide data – patient and staff ethnicity  
- Bottom up and top down  
- Zero tolerance – consistent  
- Fair recruitment process  
- BME staff to be part of workforce development | - Commitment to effective programmes consistency  
- Data is available, staring you in the face, use it!! E.g. 2008 South East study by Dr VLC – national template  
- Stand up, walk the walk  
- Engagement  
- NHS BME Network – to retain NHS logo to demonstrate commitment from NHS  
- Change the composition of Boards actively to be representative of population served. NHS TDA, NHS England, CQC, CCG, Trusts. HEE  
- Hear from BME staff e.g. CQC specific BME focus groups  
- CQC to include BME networks during inspections  
- No more auditing, no more data collection, already have plenty, Kline, West et al etc.  
- The question to ask is: is it that they don’t want to address issues or they don’t know how to!  
- Produce outcomes of what they will do to deal with BME issue  
- Produce an action plan  
- Provide deadline of when action plan will be fulfilled  
- Make the link between BME discrimination and patient safety clearer  
- We know you know. What are you going to do about it?  
- Change of structure  
- No commitment  
- Setting measurable targets to make whole system (NHS) accountable?
NOTES FROM WORKSHOP 3

1 – What message do you want the NHS BME Network to give system leaders?

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<tbody>
<tr>
<td>- More training and development for BME staff</td>
<td>- Enforce financial penalties if targets of equality have not been achieved</td>
</tr>
<tr>
<td>- More supervision and mentorship of BME staff</td>
<td>- Use authority to command / effect change</td>
</tr>
<tr>
<td>- Middle management training for BME</td>
<td>- Act like you believe it (do what you say)</td>
</tr>
<tr>
<td>- Demonstrate examples of good practice in NHS – peer review, mentorship</td>
<td>- Clear link to patient safety so needs to be addressed with same priority</td>
</tr>
<tr>
<td>- Service management recognition of BME issues</td>
<td>- Clear / defined outcomes and measurement of achievement</td>
</tr>
<tr>
<td>- Treat as equals / transparent</td>
<td>- Clear accountability and who is responsible</td>
</tr>
<tr>
<td>- Acknowledge cultural differences</td>
<td>- Use the existing data, research info to inform above</td>
</tr>
<tr>
<td>- They have failed in statutory requirements</td>
<td>- Enough of policies and processes – soft targets</td>
</tr>
<tr>
<td>- Need to accept failure and show clear action to improve</td>
<td>- Develop a strategy that serves us better than EDS2</td>
</tr>
<tr>
<td>- Equality and fair treatment of staff improves patient outcome and patient safety</td>
<td></td>
</tr>
<tr>
<td>- Reinforce engagement with staff</td>
<td></td>
</tr>
<tr>
<td>- Race equality council for all NHS Trusts led by BME interests – Board members accountable</td>
<td></td>
</tr>
<tr>
<td>- Linking action to timeframe – sanctions</td>
<td></td>
</tr>
<tr>
<td>- Evidence already available – lack of progression</td>
<td></td>
</tr>
<tr>
<td>- Recruitment – positive discrimination, development promotion, retention, fair process for recruiting</td>
<td></td>
</tr>
<tr>
<td>- Engagement with BME staff / patients on issues impacting upon them</td>
<td></td>
</tr>
<tr>
<td>- Systematic monitoring and reporting - mandatory?</td>
<td></td>
</tr>
<tr>
<td>- Timescales and accountability</td>
<td></td>
</tr>
<tr>
<td>- Recruitment – is value based recruitment the solution to inequality? Listen to experience</td>
<td></td>
</tr>
</tbody>
</table>
## NOTES FROM WORKSHOP 3

**1 – What message do you want the NHS BME Network to give system leaders?**

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</tr>
</thead>
<tbody>
<tr>
<td>- Positive role model</td>
<td>- Data: utilise and action and evaluation</td>
</tr>
<tr>
<td>- Raise the people; get BME inequalities on the agenda!</td>
<td>- Enough is enough, we need to be listened to</td>
</tr>
<tr>
<td>- Nationally recognised as a power of authority</td>
<td>- Time for action</td>
</tr>
<tr>
<td>- Solution focus – communication skill, leadership skill, our own weakness, our apathy</td>
<td>- For race equality to be prioritised!</td>
</tr>
<tr>
<td>- Communication on success</td>
<td>- Nothing will work if there's no action</td>
</tr>
<tr>
<td>- NHS needs us</td>
<td>- Celebrate good practice</td>
</tr>
<tr>
<td>- Be more visible and engage with the BME agenda</td>
<td>- Recognise our contribution</td>
</tr>
<tr>
<td>- BME Network to be seen as facilitators / not a threat</td>
<td>- Working parties (rep. service users, providers, CCGs and other stakeholders) – which represent the BME population they serve and represent people at all levels of the organisation</td>
</tr>
<tr>
<td>- BME Network to challenge / hold Trust accountable</td>
<td>- Open communication</td>
</tr>
</tbody>
</table>
## NOTES FROM WORKSHOP 3

### 2 – What will it take for local NHS organisations to deliver BME equity?

<table>
<thead>
<tr>
<th>NHS Trusts / Primary Care</th>
<th>NHS Leadership Bodies (NHSE, PHE, DH etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Better use of staff survey results</td>
<td></td>
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<tr>
<td>- Set own targets that are important to Trust</td>
<td></td>
</tr>
<tr>
<td>- Shared learning with other Trusts who are doing well</td>
<td></td>
</tr>
<tr>
<td>- Designated time for BME Leads</td>
<td></td>
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<tr>
<td>- Challenging and open culture</td>
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<tr>
<td>- Development / coaching to enable progression</td>
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<tr>
<td>- Representation on the: Boards (must be a race equality lead): Interview panel at every level</td>
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<tr>
<td>- Exit interview – electronic</td>
<td></td>
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<tr>
<td>- Education – not just online training</td>
<td></td>
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<tr>
<td>- Staff to be given time to attend BME meetings</td>
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<tr>
<td>- Employ BME staff</td>
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<tr>
<td>- CEO and Board members at provider organisations (i.e. NHS Trusts) to be held accountable</td>
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</tr>
<tr>
<td>- Positive action e.g. Executive Board members represent the local BME community and staff – through positive action</td>
<td></td>
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<tr>
<td>- Clear leadership engagement – CEO / MD / CN</td>
<td></td>
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<tr>
<td>- BME staff in key position</td>
<td></td>
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<tr>
<td>- All cases has to be resolved to show how serious they are</td>
<td></td>
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<tr>
<td>- Recruitment process – panel, promotion has to be implemented</td>
<td></td>
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<tr>
<td>- We need action rather than lip service</td>
<td></td>
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<tr>
<td>- To have more BME managers</td>
<td></td>
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<tr>
<td>- NHS organisation need to recognise meritocracy to improve BME unit</td>
<td></td>
</tr>
<tr>
<td>- Education for all staff on how to reduce inequalities and develop / nurture staff: show the data</td>
<td></td>
</tr>
</tbody>
</table>

- NHSE and CCGs and NHS workforce ensuring that BME equity features on the commissioning framework in service delivery. This is clearly monitored against specific measurable outcomes (Re-writing of policies with clear outcomes)
- Clear mandatory directive from the highest level to reduce inequalities
# NOTES FROM WORKSHOP 3

## 2 – What will it take for local NHS organisations to deliver BME equity?

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>- Positive encouragement for BME staff to apply for development opportunities</td>
</tr>
<tr>
<td>- Staff to reflect the population being served</td>
</tr>
<tr>
<td>- Work through an ‘Action Plan’</td>
</tr>
<tr>
<td>- Introduce BME Network at induction</td>
</tr>
<tr>
<td>- BME Network – supported by the organisation (time off, investment) – awareness at Board level (Director sponsor, governance agenda)</td>
</tr>
<tr>
<td>- Allocated resource</td>
</tr>
<tr>
<td>- More BME staff at Director level – access to the Board</td>
</tr>
<tr>
<td>- Effective personal development planning</td>
</tr>
<tr>
<td>- Open and transparent criteria for talent managing</td>
</tr>
<tr>
<td>- E&amp;D adviser should be in post to support staff</td>
</tr>
<tr>
<td>- As part of Trust annual plan – Trust to have an objective to improve BME staff experience – as a CQUIN?</td>
</tr>
<tr>
<td>- Acknowledge the “elephant” (problem) in the room</td>
</tr>
<tr>
<td>- Racism – stop skirting around the issues</td>
</tr>
<tr>
<td>- Ongoing public commitment and statement – Not just once…</td>
</tr>
<tr>
<td>- Publish data on BME patients and staff</td>
</tr>
<tr>
<td>- Proportionate reps</td>
</tr>
<tr>
<td>- Increase standard and not reduce it</td>
</tr>
<tr>
<td>- Value based leaders</td>
</tr>
<tr>
<td>- Put patients at the heart</td>
</tr>
<tr>
<td>- Treat all staff well, including BME</td>
</tr>
<tr>
<td>- Hierarchy to get engaged</td>
</tr>
<tr>
<td>- Better BME representation at senior level</td>
</tr>
</tbody>
</table>
## NOTES FROM WORKSHOP 3
### Improving BME Staff Experience in the NHS

2 - What will it take for local NHS organisations to deliver BME equity?

<table>
<thead>
<tr>
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<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>- BME advisory / critical friends to sense check policy etc., including recruitment decisions</td>
<td>- Action – Action – Action</td>
</tr>
<tr>
<td>- Radical change on culture from the top down</td>
<td>- Cultural change</td>
</tr>
<tr>
<td>- Organisation having a strategy that both staff and management buy into</td>
<td>- Needs to be a priority on the agenda</td>
</tr>
<tr>
<td>- CEO / Chairman attend / participate in BME Networks – action focus – regularly and feed back to Board</td>
<td></td>
</tr>
<tr>
<td>- Involvement of senior managers:</td>
<td></td>
</tr>
<tr>
<td>· Acknowledge the issue, not denial</td>
<td></td>
</tr>
<tr>
<td>· Take positive action</td>
<td></td>
</tr>
<tr>
<td>· Recognise and promote the whole of the talent pool, including BME staff</td>
<td></td>
</tr>
<tr>
<td>- Table ‘Snowy White Peaks’ at Trust Board and set an action plan which the Trust Board is held to account to deliver</td>
<td></td>
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<tr>
<td>- Better understand the need of their BME staff, this will help understand the needs of patients</td>
<td></td>
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<tr>
<td>- More understanding of their role</td>
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<tr>
<td>- Support the BME by recognising their input, skill, profession or payband</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS BME Network / BME Staff</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>- Sanctions – ranking organisations</td>
<td></td>
</tr>
<tr>
<td>- BME should be more visible</td>
<td></td>
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<tr>
<td>- Roadshows</td>
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</tbody>
</table>
# NOTES FROM WORKSHOP 3

## 3 – What actions need to be taken to improve BME unity?

<table>
<thead>
<tr>
<th>NHS Trusts / Primary Care</th>
<th>NHS Leadership Bodies (NHSE, PHE, DH etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Recruitment and selection</td>
<td></td>
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<tr>
<td>- Representation at senior levels</td>
<td></td>
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<tr>
<td>- Orientation to organisation</td>
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<tr>
<td>- Positive action programme:</td>
<td></td>
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<tr>
<td>- Open access</td>
<td></td>
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<tr>
<td>- Staff engagement programme by employers</td>
<td></td>
</tr>
<tr>
<td>- Open dialogues and action learning sets</td>
<td></td>
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<tr>
<td>- Leadership within BME staff</td>
<td></td>
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<tr>
<td>- Staff development</td>
<td></td>
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<tr>
<td>- Breaking down of barriers</td>
<td></td>
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<tr>
<td>- Education opportunities</td>
<td></td>
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<tr>
<td>- Stop focusing on the differences instead celebrate our uniqueness and similarities</td>
<td></td>
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<tr>
<td>- Challenging unconscious biases</td>
<td></td>
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<tr>
<td>- Protect staff who raise concerns from negative consequences</td>
<td></td>
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<tr>
<td>- Terms of Reference</td>
<td></td>
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<tr>
<td>- Action Plan</td>
<td></td>
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<tr>
<td>- Provide time for members to attend meetings etc.</td>
<td></td>
</tr>
<tr>
<td>- Courage to challenge NOT put and shut up</td>
<td></td>
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<tr>
<td>- Open and honest, patient centric and staff focused</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS BME Network / BME Staff</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Maintain focus on bigger picture i.e. equality for all</td>
<td></td>
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<tr>
<td>- Not to focus on short-term goals and personal agenda</td>
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<tr>
<td>- Find common ground, not focus on differences</td>
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</tbody>
</table>

- Provide Trusts with incentives for giving time to staff to attend?
- Learn from other organisation e.g. prisons
- Develop outcomes criteria to monitor improvement – commissioning process, NHS England, HEE
- The wider NHS understand and act on this as an issue e.g. like the NHS did for MRSA, C. diff – ownership of the problem as an NHS wide issue

- Monitor. Accountability and consequences?
- CEO and system leaders need to be held to account
- BME role models
- BME leaders may be biased
NOTES FROM WORKSHOP 3

3 – What actions need to be taken to improve BME unity?

<table>
<thead>
<tr>
<th>NHS BME Network / BME Staff</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Working together amongst ourselves and information sharing (data, statistics)</td>
<td>- Dialogue, education of our differences come together</td>
</tr>
<tr>
<td>- Regional network meetings for BME networks</td>
<td>- Sharing good practice</td>
</tr>
<tr>
<td>- Make a positive message that BME groups will improve safety, outcomes and experience for patients</td>
<td>- We need to have good leaders</td>
</tr>
<tr>
<td>- Reduce perception of BME Network as a ‘protest group’</td>
<td>- Mission Statement</td>
</tr>
<tr>
<td>- Work with the Trust / community</td>
<td>- Learn from organisations who are doing better</td>
</tr>
<tr>
<td>- Encourage attendance of meetings</td>
<td>- Focus and respect</td>
</tr>
<tr>
<td>- Leaders must unite, work with other BME leaders, integrate ourselves</td>
<td></td>
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<tr>
<td>- We must show leadership our patients deserve</td>
<td></td>
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<tr>
<td>- Must bring good white people on board</td>
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<tr>
<td>- We have to believe it, collectively</td>
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<tr>
<td>- Participation / support</td>
<td></td>
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<tr>
<td>- Commitment as a BME support</td>
<td></td>
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<tr>
<td>- Personal responsibility</td>
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<tr>
<td>- Start small think big</td>
<td></td>
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<tr>
<td>- Think about the personalisation agenda</td>
<td></td>
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<tr>
<td>- Awareness and sharing openly our experiences, communication is key to achieving great outcomes</td>
<td></td>
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<tr>
<td>- Utilise BME Networks – share information</td>
<td></td>
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<tr>
<td>- Discrimination amongst ourselves</td>
<td></td>
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<tr>
<td>- Regular set meetings</td>
<td></td>
</tr>
<tr>
<td>- More social events / gatherings</td>
<td></td>
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<tr>
<td>- Acknowledge differences and make these differences our advantage</td>
<td></td>
</tr>
</tbody>
</table>

- All
WORKSHOP 4

Hear Me Now - Prostate Cancer in Black Caribbean and Black African Men

Chair - Rose Thompson
Director
BME Cancer Communities

Prostate cancer is the most common cancer in men; fortunately many patients survive and go on to lead fulfilling lives. However, there is an uncomfortable reality in prostate cancer notably that black-African-Caribbean men are 30 per cent more likely to die from prostate cancer than white men. Black men have a three-fold greater risk of prostate cancer than white men and are more likely to encounter prostate cancer at a younger age.

This is a stark and unacceptable inequality and action in required to improve the outcomes for black men with cancer. This workshop will explore how the outcomes can be improved both at a national and local level and how BME Cancer Communities currently strives to making this a reality.
NOTES FROM WORKSHOP 4

1 – What can the BME Network members do to increase positive action to support the Hear me now campaign?

- External to the workplace for example churches
- Locate where BME people gather
- Break down language barriers
- Education and awareness – family, specialist, experts in the field
- Prostate risk assessment tool
- New urine test (USA)
- Word of mouth – men speak out
- Simple blood test
- Educate GPs – men must be allowed access to PSA on request – regular tests
- PSA and rectal exam
- Women encourage men
- Community groups and religious groups
- Black famous people encourage involvement
- Focus on young people – relevant way
- Social media

2 – What question would you like to ask?

- How do you get beyond the “fear, taboo” that men face with any issue relating to “private genitals”?
- Any connection between sex and prostate cancer?
- Are Afro-Caribbeans more sexually active?
- Why hasn’t there been an accurate screening tool developed?
Victoria Macdonald

Health and Social Care Correspondent
Channel 4 News

Victoria Macdonald is Health and Social Care Correspondent at Channel 4 News.

Victoria Macdonald is an award-winning journalist, who has been covering health and social care issues for Channel 4 News since 1999. She closely follows the changes and developments in the NHS and the care system from the scandal at Mid Staffordshire NHS Trust to the wholesale reforms of the health service.

Victoria also reports on medical developments, mental health issues as well as covering stories on how welfare reforms are affecting those with physical disabilities. And she closely watches developments in HIV/AIDS and TB.

Victoria is originally from New Zealand and worked for the Sunday Telegraph before joining Channel 4 News.
Conference Feedback

Last time I stood in front of you I was inspired by the passion in this room - by the belief in the need that things must change.

First of all, we should thank Vivienne for her complete dedication.

My job today is to sum up the day and frankly it is the hardest job because it is not just about summarising what we heard in here but also from what I have heard from elsewhere in the conference.

It would be tempting to just give you all the data that was presented by Roger Kline and Vivienne because it was so powerful. But that would be boring and lazy of me.

We started the conference with the question is BME equity a reality in the NHS today? 76 per cent said no

There has been an overwhelming feeling as I have talked to people around the room that this is taking too long. That there is a lot of talk and not enough action. Why are you still here in 2014?

So, as Vivienne and Professor Robert Beckford (congratulations by the way on the promotion) said: ‘Today is Time For ACTION’. And that you have to be the driving force for change. That is a positive way to begin a conference.

And the scene was set both by Vivienne and Roger Kline.

And this was backed up by the data presented here. One chair and no chief executive in NHS trusts. A decrease in the proportion of BME board members. How much better could the title of that report be than Snowy White Peaks?

Morecambe Bay.
2 per cent ethnic minorities. 83 per cent of the untoward incidents.

I am putting out a film next week on inquests and parents not being given them when they should. When I pointed out to the solicitor that her clients were all BME she said she hadn’t noticed. That she was colour blind. My thought was this was a time not to be colour blind. Report next week.

We heard of the bullying, the lack of career progression, the failure to access training programmes.

Whistleblowing. Particular interest of mine. It had not escaped my notice that a disproportionate number of the whistleblowers are from BME backgrounds. Up against the conservative structures of the NHS. Time and again the protection of whistleblowers has come up here today.
On the question of discrimination. More than a third of you believe that the barrier to change is institutional and individual racism.

Who is ever punished or sacked? Little or no action is ever taken. With Vivienne's help I have recently done an FOI asking that question. One or two here or there. My conclusion, if i was more gullible, would have been that it isn’t going on....

And talking about those. CQC. Mike Richards. The two notes I took on that was more training on equality and talking to specific equality groups but I got the impression you were not impressed.

That CQC should perhaps have been further along on this than they are.

Yet on the theme of new structures within the NHS - NHS England. Ruth Passman talked about the opportunities for improvement under the health and social care act and NHS Outcomes Framework.

Simon Stevens has already chaired meetings with Roger Kline was there to present his snowy white peaks work.

The equality diversity council has been re established, there is the NHS leadership academy.

How many of you knew this was happening is the first question?

How many of you believe it will make a difference. It turns out 75 per cent of you don’t think it will.

I agree with one of the delegates here who asked how are organisations going to be made to prioritise this?

But more optimistically I think it matters that Simon Stevens has done this within months of being in post. I see that as a positive move.

Heard from lived experience champions. The barriers that are piled on top. A criminal record, a long term condition, mental health issues.

Julie Bailey. - I meet a lot of campaigners in my daily work but there are few I have met who I admire as much as Julie. Because when the inquiries had been held, when people had lost their jobs she didn’t just say job done and go back to her own life, but she has kept going because she could see that mid staffs was not isolated.
There is a lesson for all of us ... I highly recommend her book From the ward to Whitehall.

At the workshop I went to

How to change?

Get a place at the table

Don’t wait to be asked. Demand a place, demand change.

Go and seek out good practice like in Wigan.

Develop strategies to make change happen.

Demand better data

As a patient, demand your rights.
Give them your experience to make changes happen

And importantly Make the BME Network a national body.

Thank you