1 **Purpose of the Report**

The purpose of this report is to update the Edinburgh CHP Sub-committee on how it is currently addressing the health issues of its minority ethnic community (BME) \(^1\) and invite the CHP to consider ways of improving progress on this.

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2 **Recommendations**

The CHP Sub-committee is invited to:

2.1 To acknowledge that reducing health inequalities in BME communities requires recognising the increasing diversity within the BME sector and within cultural groups including Gypsy/Travellers, refugees and asylum seekers and A8 migrant workers (3.1).

2.2 Endorse the culture/language specific linkworker role as a model of good practice and invest in increasing the capacity for current and additional culturally specific link-workers to bridge people into services and meet unmet need giving priority to the needs of the African and Gypsy/Traveller communities in addition to the service. This would include retaining one linkworker Health Visitor for the

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\(^1\) BME refers to Black and Minority Ethnic communities
Edinburgh Refugee Centre to provide sessional input on an as required basis (5.3.3).

2.3 Acknowledge that this work requires inter-agency working with GPs and primary care teams playing a key role in providing improved access to services and information supported by the Minority Ethnic Health Inclusion Service (see 4.3).

2.4 Acknowledge that the Minority Ethnic Health Inclusion Service (MEHIS) activities need to be integrated into the LHP Operational Plans to help support the work of LHPs in helping the CHP to deliver its plans and recognise that this will require additional resources to build the capacity of the service (examples 4.2).

2.5 Acknowledge the service pressure caused by the current funding issues related to in the text and report on resource implications (see Section 6).

2.6 Consider the existing funding to enable the Khush Dil Support Workers to continue to focus on lifestyle issues in South Asian communities and reduce the risk of CHD and diabetes in this high risk group (4.3).

2.7 Acknowledge that all functions, strategies and new and revised policies within the CHP should be Equality Impact Assessed prior to approval to ensure that the needs of minority groups are considered and barriers to services which may be both cultural and related to communication needs are addressed (5.1).

2.8 Acknowledge the need to collate data on ethnicity, language preference and additional support needs at registration with GPs and Dentists to monitor the uptake of services effectively and ensure that this information travels throughout the patient pathway to improve accessibility and continuity of care (4.2).

2.9 To consider the needs of minority groups in the allocation of resources traditionally targeted to geographic areas of deprivation recognising that many BME people live in areas such as Gorgie, Dalry and Tollcross in private, often overcrowded tenanted accommodation and experience socio-economic disadvantage as do those BME people resident in the regeneration areas (5.1).

2.10 To acknowledge that the CHP is legally required to meet its commitments as laid out in the NHS Lothian’s Race, Disability and Gender Equality Schemes and its Equality and Diversity Strategy, available on the NHS Lothian website, and needs to formalise and agree action to address these. The CHP is asked to consider identifying Equality and Diversity champions at senior management level who would have a lead Equality and Diversity role in their designated area as part of their remit across the CHP’s areas of service to drive the changes required. The Health Inequalities Manager, accountable to the CHP General Manager would form an implementation group of champions to lead activity and monitor and review progress. This would support the CHP to promote this agenda and make the required changes within the CHP services. (5.1)

2.11 Receive in the future more detailed reports on progress, issues and challenges across the other five equality strands including age, disability, faith/belief, gender
and sexual orientation recognising that many people experience multiple discrimination in all aspects of their lives and inequalities in health.

2.12 To ensure that GPs through the procurement/contracting process comply with the legislative equality requirements of the CHP in all contracts (5.1).

2.13 The CHP is asked to withdraw the requirement on the Health Inequalities Department to make a £9,000 CRES saving this year on a budget which is already under funded. This cannot be met without a reduction in service which would hit the Arabic/Muslim community in particular as this service is currently provided by sessional staff. This group, as other minority groups, are particularly vulnerable and will be unfairly discriminated against if this service requires being withdrawn. It is not realistic to expect a service which is already under funded and inadequately resourced to make such savings and it has always in previous years been exempt from CRES (6).

3 Summary of the Issues

3.1 BME communities have been resident in Scotland for many years. The diversity in these minority ethnic communities will continue to grow as the Scottish Government reports the biggest inward-migration figures in 50 years\(^2\). BME health needs were largely neglected before the Race Relations (Amendment) Act 2000. A notable exception was the development of the Minority Ethnic Mental Health Strategy (1995) developed in partnership with BME communities in Edinburgh. (See 4.2).

The most socially excluded BME communities suffer high levels of deprivation and have multiple and complex needs. A high percentage of people in some communities such as the Bangladeshi community are trapped in inter-generational cycles of inequality, ill health and lack of opportunity. They are unwittingly excluded not only from health and social care services but also other welfare and voluntary sector services. These communities are paternalistic in terms of power and dominance but not in terms of welfare. Gender and religious beliefs play an additional role in creating further inequality between genders.

The most socio-economically disadvantaged groups will suffer disproportionately from the impact of newer and higher levels of discrimination. Individuals have reported reduced opportunities for employment, housing, English language classes and other activities which may result in health gain. The most significant impacts on health are related to:

- Racism
- Language and cultural barriers
- Low pay
- Split families and having to support families ‘back home’
- Poor housing and multiple occupancy
- Higher prevalence of conditions such as CHD and diabetes in South Asian communities

\(^2\) Inward migration in Scotland has been supported under schemes like Fresh Talent, Highly Skilled Migrants, provision of Work Permits and International students.
• Social exclusion leading to isolation and increased risk of mental health problems

3.2 There are currently three models of service intervention to address health inequalities in the BME communities. All interventions are underpinned by the NHS Lothian Strategic Action Plan on Minority Ethnic Health: Being Fair for All in the NHS in Lothian and the Race Equality Scheme. An action plan focuses work under the following headings: leadership; demographics; access to services; human resources and community development (see 5).

4 Key Issues/Progress

4.1 Cultural/language specific linkworkers

Minority Ethnic Health Inclusion Project (MEHIP) has recurring funding for 4.68 WTE linkworker/advocates for Bangladeshi, Chinese, Indian/Pakistani and Refugee/Arabic communities to provide a Lothian wide service. The funding has not increased since 2001 despite higher demands due to the increase in diversity and implementation of the Race Relations (Amendment) Act 2000. The focus in MEHIP is on bridging between individual need and primary care services. There were 234 new cases in 2006-7 which included support to access registration with GPs and dentists as well as for those needing advocacy support for complex physical health problems, domestic violence and a wide range of other health issues.

56 Health awareness/promotion sessions were provided including access to health services, cancer, diabetes, smoking/paan cessation, 1,919 people from BME communities have attended. Many group sessions were done in partnership with other voluntary sector organisations and additional information stalls with MEHIP providing access to specialist health expertise. There are effective links with the Edinburgh Refugee Centre and a MEHIP session is provided per week when staffing levels permit.

There is no identified linkworker for the African or other incoming communities, not including the A8 European migrants who currently have different requirements (see below). The gaps in addressing the specific needs of African and other communities is an area of concern as many experience socio economic and health problems related to unemployment and low wages, poor housing and domestic abuse, have language barriers and lack information and support to access services. The need for an African linkworker post was identified as a priority by the joint Edinburgh Race Equality Forum.³

_Health Visitor for Gypsy/Travellers, WTE 0.5_ recurring funding providing a service to primarily roadside Gypsy/Travellers in East, Mid and Edinburgh, based in the Dalkeith Medical Practice. Link Health Visitors have been identified to make good the deficit in service lost when half the funding for this post was used to make CRES. There is concern that they will be unable to provide the continuity, responsiveness and flexibility to respond to new arrivals and local knowledge of temporary pitches. Gypsy/Travellers have an average life expectancy of 55, the lowest of all our communities. Direct access to maternity

³ The Edinburgh Race Equality Forum is a representative group from BME communities across Edinburgh who meet with Equality ‘officers’ from the City of Edinburgh Council., Lothian and Borders Police and NHS Lothian. The Health Inequalities Manager is the Lothian NHS representative.
and gynaecological services and Emergency Dental treatment has been negotiated and the development and use of handheld records will help to co-ordinate treatment. It is argued that this community requires a full-time worker for Edinburgh, Mid and East Lothian dedicated and able to respond flexibly to local knowledge of roadside encampments and the health needs of the Gypsy/Travellers. Current concerns include child protection, access to immunisation and health screening which cannot be adequately addressed within this resource. The current part-time post-holder is on a phased return to work after a period of long term sickness. The Link Health Visitor model should be reviewed after a year to ensure that it is working effectively.

4.2 **Generic linkworker**

Minority Ethnic Mental Health Project, MEMHP, WTE 0.93, recurring funding, but historically this post has never been fully funded. This project provides support and advocacy for BME people with mental health problems both in hospital and in the community and supports clinical staff. The post was originally established for the South Asian community but is now required to meet the needs of all BME communities. During 2006-7, 70 patients were supported. In addition MEMHP worked with local community groups to provide mental health awareness and promotion sessions to increase knowledge of mental health services in the community and challenge stigma. 17 mental health promotion sessions were held and 211 people participated.

4.2 **The Minority Ethnic Health Inclusion Service** (MEHIS) is a ‘virtual’ service and comprises these three projects, MEHIP, MEMHP and the Gypsy/Traveller Health Visitors providing a bridge in to primary care and mental health services and to the BME voluntary sector and are resourced to provide culturally appropriate interventions. MEHIS works to ensure that BME communities have access to health information, health promotion and prevention messages which are culturally competent. For all BME communities MEHIS staff are involved in assisting with ‘health literacy’:

- Navigating the NHS
- Communicating with health staff
- Accessing information related to their own health care

MEHIS has a training and facilitation role to:

- Build capacity within NHS Lothian, essential to the promotion of mainstreaming and integration of BME health
- Transfers the MEHIS ‘know how’ to practitioners within the practice context, to improve the quality of health services as experienced by the patient
- To build cultural competence at both policy and practice levels

Linkworker roles can be tailored to meet the needs of specific services. STOP SMOKING service proposal supports the use of linkworkers to work alongside smoking cessation co-ordinators to facilitate group support in various forms of tobacco use.

SCELHP is beginning to mainstream and integrate minority ethnic health in to their Local Operational Plan

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4 Two sessions per month on average is provided to health professionals and trainees.
4.3 Disease specific models, Khush Dil and the Diabetes project

These short-term funded projects have focussed on the needs of specific communities which are recognised to have an increased risk of CHD and diabetes and have been reported on separately. As the funding comes to an end in March 2008 work is ongoing co-ordinated formally by Tim Montgomery, previously Assistant General Manager and now by Dr Margaret Douglas in Public Health, to ensure that the learning from the projects can be mainstreamed. Recent work towards this has included a community worker from Khush Dil and Lubna Kerr, community pharmacist, and a specialist diabetes nurse working with two practices to complete joint diabetes/CHD risk clinics, using practice lists to identify South Asian adults with these conditions. Involving linkworkers with families during the cardiac rehabilitation programme may also be an opportunity but also put additional demands on a limited resource. The monitoring of the uptake by minority ethnic patients in the roll out of Khush Dil learning through Keep Well will be monitored through the Action Group (Dr Margaret Douglas). As Keep Well is targeting practices in regeneration areas many ethnic minority people at high risk will miss out on this opportunity as they live outside the designated areas.

The funding for Khush Dil and the diabetes project runs out by the end of March 2008. The two support workers in Khush Dil will be transferred to MEHIP to focus on lifestyle issues (diet and exercise) in South Asian communities till March 2008. Additional funding will be required to cover their costs from April 2008 and if funding cannot be identified staff will require going on the redeployment register from December.

5 Impact on Health Inequalities

5.1 Leadership

The responsibility for Equality and Diversity is shared between the following Executive Directors of NHS Lothian, Dr Alison McCallum Public Health and Health Policy, Jim McCaffery, Human Resources and Heather Tierney-Moore for Public Involvement. The Health Inequalities Manager, a member of the NHS Lothian Equality and Diversity Steering group has lead responsibility for Equality and Diversity in primary care and is ‘hosted’ by the Edinburgh CHP, accountable to David Small, General Manager and is responsible for Equality and Diversity in Edinburgh, East Lothian and Midlothian CHPs as well as holding a range of other responsibilities. To enable effective implementation of the strategies and schemes mentioned earlier in 2.7 this role needs to be integrated in the work of the CHP at strategic level to ensure best practice and legal requirements are met. The Health Inequalities Manager is the manager of MEHIS and has a role to influence work with other public sector organisations in Lothian and at a national level to achieve progress in outcomes to tackle inequalities in health. EQIA training and implementation is essential in all CHP strategies and policies to ensure that the needs of minority communities are considered and reduce any adverse impact on vulnerable groups.

5.2 Demographics

The CHP is not yet routinely collecting information across equality strands including ethnicity and preferred language to enable it to make the best use of
data collection to inform policy and practice interventions to improve health across all equality strands.

5.3 Access to services

5.3.1 The role of the culturally specific linkworkers is essential to enable BME communities to access health services and identify gaps in service provision and practice. MEHIS provides a bridge into primary care and mental health services and the BME voluntary sector services. Additional resources need to be identified to address the gaps and reduce the risks particularly for the African and Gypsy/Traveller communities.

5.3.2 Both the Refugee Health Forum and Gypsy Traveller Health Forums, chaired by the Health Inequalities Manager, help to influence practice across health, local authority and voluntary sector agencies to coordinate activity and achieve health improvement for these groups.

5.3.3 The previous identification of link Health Visitors for Asylum Seekers needs to be revised to reflect the drop in the number of refugees and asylum seekers in Edinburgh. It is recommended that one HV/Community Health Nurse be identified to be accessible to the Refugee Centre on an as required basis, equivalent to a session a month.

5.3.4 A joint Edinburgh migrant worker forum helps to coordinate links with community representatives from the A8 communities. These communities are predominantly young, single, healthy, well educated, and economically active and rely relatively less on public sector services than indigenous communities. They live in private rented secure and sometimes overcrowded accommodation. They are benefiting from information about NHS services available in their own language. They see themselves accessing mainstream services independently, relying on interpreters and not as yet requiring linkworkers, although this will need to be kept under review as the needs of the population changes. Significant health issues are few and a report was recently completed for the Director of Public Health advising that the main health issues related to registration, maternity, family planning and alcohol misuse. The impact on CHP services has been:

- Increased number wishing to register with GPs and dentists.
- Increased use of family planning and also maternity services.
- Increased number of child protection cases
- Impact of loneliness and social isolation
- Increased incidence of domestic abuse
- Alcohol related problems
- Pressures associated with providing continuity of care.
- Increased demand for interpreters and translation services
- Coping with different expectations from the NHS from the migrant population as a result of their previous experience of a medical led and very different system.
- Lack of knowledge amongst local health care staff of the health systems that the new migrants have previously experienced.

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5 The Family Planning service has employed a Polish administrative worker on a pilot basis with additional responsibilities to act as an in house interpreter to meet the needs of the increased number of Polish women attending the service
5.3.5 Access to interpreters\(^6\) has and continues to increase per year (52.3% last year) and emergency access to telephone interpreting is now available to all GPs in Lothian. Interpreting costs will continue to soar and are paid through a central budget at the Deaconess for NHS Lothian. Translation costs have increased by 66% this year, at a cost of £20 per hundred words\(^7\) and will continue to increase. These costs have to be met by individual services unless it has a Lothianwide application and can be negotiated centrally through the Communications Department at Deaconess.

When interpreters are required it is good practice to allow double appointments for BME patients to allow for the additional interpreting time. MEHIP’s audio-visual resources proposal, currently being discussed at the National Resource Centre for Ethnic Minority Health with NHS Health Scotland provides a potential solution to cut interpreting costs. Routine information on access, procedures and roles of health professionals can be provided by a click of a button. Face to face interpreting which takes double time for the health professional and the interpreter can then be reserved for individual health needs.

5.3.6 Some services remain inaccessible to some BME community members where there is no provision to provide gender specific interventions. Male patients may need assistance or advocacy from a male linkworker or Arabic women need a female worker for reproductive or gynaecological issues. The replacement of a female linkworker post for Refugees and Arabic people by sessional workers who are employed on an as required basis has increased the flexibility of the team. However this resource is limited and sessional workers require significant additional management support with consequent implications for the project manager’s capacity\(^8\).

5.3 Human Resources

The CHP needs to ensure that employees reflect the diversity of the local population. An employment strategy to take positive action to increase recruitment from BME communities should be a target for action. All staff have equality and diversity training as part of induction but front-line staff also need further training across all equality strands to enable them to provide services in a way that takes account of age, disability, gender, faith/belief, ethnicity and sexual orientation. Many people experience multiple discrimination.

An ethnic minority component in training programmes will be targeted at specific staff groups to train health trainers and promote awareness with key staff of the health needs of minority ethnic communities.

5.4 Capacity Building in the Community

MEHIS works towards this objective through partnership working and assisting community organisations to meet the needs of community groups. Work is in progress in relation to training voluntary sector organisations to deliver CHD lifestyle components (4.3), mental health awareness (4.1) and other health related issues (4.1).

The Health Inequalities Manager works closely with the City of Edinburgh and Lothian and Borders Police Equality units to collaborate with BME and other

\(^6\) Numbers of hours of interpreting in 2005-6, 3727, number in 2006-7 5,678.

\(^7\) Number of words translated in 2005-6 19,800, number in 2006-7 49,800

\(^8\) The MEHIP Project Managers hours were increased to full-time on a temporary basis to support this. A permanent full-time MEHIP Team Leader is essential but the current funding for this will be dependent on the withdrawal of the CRES target.
communities through our joint support of Equality Forums and integration of equalities work. The joint Equality Forums can contribute to involvement and consultation on CHP issues in parallel with the Public Partnership Forums to increase the voice of minority groups. Work is planned to formalise this in 2007-8. There is current work in progress on providing joint training and information to the joint Equality Forum members.

The NHS Lothian Minority Ethnic Health Forum monitors progress in the implementation of Race Equality work across all NHSL services and helps to identify priorities for action.

6 Resource Implications

6.1 The resource implications are:

- Funding for MEHIP Team Leader to be full-time (to increase post from 30 hours to 37 per week) **£7,422**
- Additional culturally specific linkworker time to meet the current unmet needs of new and existing communities **£27,589**.
- Sessional Linkworkers at A&C 5 at mid-point (equivalent to part-time 18.5 hours) **£12,654**.

This would provide extra hours to increase diversity in cultures and language and allow for more intensive work around health inequalities and East, Mid and West Lothian. It is a continuing challenge to reach the most disadvantaged and house-bound people in the communities who are not registered with GPs within the current limited MEHIP resource which has a Lothianwide remit and is insufficient to provide a comprehensive service. Additional resources would provide for sessional workers to support additional communities who need the input from culturally specific linkworkers if they are to engage and be supported to access health services and improve their health and wellbeing.

- Part-time funding for Gypsy Travellers Health Visitor, shared cost with other CHPs in East and Midlothian, to make the current part-time funded post back to its previous full-time, dependent on the outcome of an annual review of the new arrangements **£15,967**.
- As required sessional input from a Health Visitor to the Refugee Centre should be met within existing resources through a minor reallocation of workload. **Cost neutral**
- Funding to support the continuation of the two part-time sessional posts in Khush Dil to continue life style work in the community for BME people **£20,520**
- Funding to address the historical budget gap in the MEMHP post. **£14,040**
- Withdrawal of Health Inequalities Department CRES target **£9,000**

Lesley Boyd
Health Inequalities Manager for primary care services
9th October 2007