Working towards racial equality in health care

The Haringey experience

Nirveen Kalsi

and

Pamela Constantinides

Haringey Health Authority

Primary Health Care Group
King's Fund Centre for Health
Services Development
126 Albert Street
London NW1 7NF
KFC 88/75

Nirveen Kalsi is a sociology graduate and has a masters degree in social and public administration. She has been involved in community development and equal opportunities issues for the past 9 years. Her appointment as ethnic minorities development worker in Haringey was the first appointment of its kind in the NHS. She is presently working as a race equality adviser with the London Borough of Southwark.

Pamela Constantinides is an anthropologist with experience of health issues in the developed and developing world. Her current research interests include community health education, social aspects of genetically inherited disease, inequalities in health and the delivery of primary health care. She is an Honorary Research Fellow in the Evaluation and Planning Centre for Health Care (EPC) at the London School of Hygiene and Tropical Medicine.

The Primary Health Care Group is a multidisciplinary team based at the King's Fund Centre for Health Services Development. Its aims are to improve primary and community health services, particularly in inner London; to encourage experiments with new ways of working; to disseminate 'good practice'; and to contribute to debates about primary health care policy. The group provides information and advice about primary care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes papers and reports.

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Foreword

Whilst monitoring facilities for the elderly in the North East Thames Region I noticed all too often that the number of black and minority ethnic patients treated did not match the proportion of those groups in the community where the facilities were available, and when I used to ask the reason the stock answer was 'they don't need these facilities, they look after their own'. Similarly, I became aware that there was something wrong in the number of black and minority ethnic patients treated in the facilities for the mentally ill.

It was already apparent to me that whilst many black and minority ethnic people worked in the NHS, there was an inbalance in the staff mix — especially in the higher grades, in certain professions and particularly in management.

All these factors contributed to my interest in the questions of equal opportunities and health care needs of the black and minority ethnic groups, so it was with pleasure that I accepted the invitation to serve as the chairman of first the working group to help steer the pilot scheme which is described in this report, and then secondly, to chair the twin working parties on the health care needs of ethnic minorities and implementation of the equal opportunities policy.

The first few steps in the adoption and implementation of plans to cater for the real needs of the black and minority ethnic groups have been taken, but the work has really only just begun.

Hannah Lipson Chairman Health Care and Ethnic Minorities Steering Group Haringey Health Authority

Acknowledgements

Though this is the report of a King's Fund project, it is also about the influence of a worker in a key post, Nirveen Kalsi, Ethnic Minorities Development Worker in Haringey, and those who have supported her in a challenging, sometimes difficult, job. No matter how needed or how well structurally supported, any innovative health service post must in the end rely in some measure for success on the commitment, energy, motivation and personality of the post holder. Inevitably in a report such as this there is only time to cover the basic elements of the development worker's task. There remain innumerable associated tasks, initiatives and committee inputs which, though they have absorbed a great deal of the development worker's time, will bear fruit in the long rather than the short term.

Jane Hughes, Co-ordinator of the King's Fund London Programme, played a leading role both at the inception and during the course of this project, offering advice and constant support and guidance.

The Haringey Health Care and Ethnic Minorities Steering Committee has been chaired throughout by Mrs Hannah Lipson, Member of Haringey Health Authority, with a wholehearted commitment to the principles and aims of the project.

Many members and officers of Haringey Health Authority, as well as of Haringey Community Health Council, the Haringey Community Relations Council and local community groups, have assisted and encouraged the development of the project. Some of the people concerned have now left Haringey. Whilst it would not be possible to mention here all those involved, several of those still working or still in contact with Haringey were interviewed prior to the writing of this report. They are Catherine McLoughlin, District General Manager, Haringey Health Authority; Barbara Young, District General Manager, Parkside Health Authority, and Haringey's District Administrator at the inception of the project; Hannah Lipson, Health Authority Member and Chair of the Project's Steering Committee; Angela Greatley, Service Manager, Care of Elderly People; Su Kingsley, Mental Health Services Manager; and Lilias Gillies, Secretary of Haringey Community Health Council. Thanks are due for their thoughtful comments.

Introduction

In 1944 a government white paper set out the ideals of the new national health service — that it should be 'comprehensive in two senses, first that it is available to all people and, second, that it covers all necessary forms of health care'.[1]

The post-war period was one of recovery, growth and development. By the 1950s Britain, always a more heterogeneous society than is popularly supposed, was encouraging the recruitment and settlement of considerable numbers of workers from her colonies and former colonies. By the end of the 1960s, when the period of large-scale immigration had come to an end, there had been marked changes in the ethnic composition of British society, especially in urban areas. By the late 1970s it was becoming clear that the hopes and aspirations of many of these newest Britons were not being fulfilled. Racial discrimination and the beginnings of economic recession were combining to exclude particular groups of people from the social and economic mobility of the early post-war decades. An increasing number of articles in health service, academic and community journals warned that the National Health Service was also failing to meet adequately the needs of the settlers and their British-born descendants. They criticised employment practices in the NHS; pointed out gross inequalities in provision of services; and began to discuss 'equality of opportunities' in both NHS employment and access to health services.

Following the 1976 Race Relations Act, the Commission for Racial Equality (CRE) published guidelines for employers on equal opportunities in employment and on the monitoring of equal opportunities policies.[2] These were brought to the attention of health authorities in a 1978 DHSS health circular [3] which spelt out the terms of the act as they affected health authorities.

In 1984, the CRE issued a code of practice for eliminating racial discrimination and promoting equal opportunities. In 1985 the London Association of Community Relations Councils surveyed the progress of equal opportunities in employment in London's health authorities. Its report, In a Critical Condition, showed how far most health authorities had still to go.[4]

In response to issues of service delivery, the DHSS adopted a 'problem oriented' approach. It launched two major national campaigns, the Stop Rickets Campaign and the Asian Mother and Baby Campaign. Through these campaigns, the role of 'linkworker' came to be seen as one means of overcoming 'cultural and linguistic barriers between health professionals and patients'.[5]

Meanwhile, local authorities with substantial black and ethnic minority populations had been moving slowly, if not always smoothly, forward. Equal opportunities policies had been drafted and in some cases implemented. Race relations advisors had been appointed, working alone or as part of a race relations unit.[6] Consultative arrangements with black and ethnic minority community groups were being developed.[7]

In the face of this activity, health authorities were coming under increasing pressure, from within and from without, to become more responsible to those they employed and more responsive to all sections of the communities they served.

In some areas community health councils (CHCs), as statutory representatives of health service users, had already taken the lead. Brent CHC published a report on black people in the health service.[8] Several CHCs initiated linkworker/patient advocate schemes, often on very limited funding.[9] This opened a pathway for dialogue between different community groups and providers of health services. Health service managers, as well as some CHCs themselves, were taken aback to find their services and their representativeness coming under articulate and often bitter criticism. People from black and ethnic minority groups made it plain that they were not willing to have their health needs defined for them. They wished to express these for themselves and they wanted to have a say in the planning of services directed towards them.

It was at this point that some health authorities began seriously to tackle the twin issues of equal opportunities in employment and appropriate service delivery to black and ethnic minority groups.

The Haringey ethnic minorities development worker project was the first of its kind in the London area.[10] The following chapters describe the background to this project, explore the way in which it developed and outline its future direction. The report does not analyse the role of development worker in a health service context, for that is a wider issue. It is a description of the role of one development worker and what she was able to accomplish.

Each health authority has its own particular circumstances and constraints. It is hoped that the discussion in this report of some of the problems envisaged, encountered, overcome or unresolved, may help to draw out the lessons learned from the project for those authorities wishing to embark upon a similar course.

1. Setting up the project

Haringey has a very mixed population with a substantial proportion of black and ethnic minority residents from a wide variety of origins. In common with several other parts of London, Haringey also has considerable areas of poverty, with social, economic and environmental deprivation. By the end of the 1970s, Haringey Health Authority had become aware that it was not responding in a concerted way to the health needs of its diverse population. In particular it felt that its response to the needs of the different ethnic groups had been piecemeal and 'problem oriented'.[11]

At a King's Fund meeting in 1982, it was suggested that since local authority race relations advisors had been effective in promoting change, this might be adopted as a model by health authorities. In 1983, a series of informal discussions between Haringey's district administrator, district medical officer and King's Fund staff, Haringey Council's race relations unit and the community health council, crystalised into an application to the King's Fund for a grant to tackle the issues of race and service delivery in a systematic way. The proposal sought the services of a development worker who would help the authority carry forward an outline plan of action, making the issues of equality in employment, service provision and access integral to the authority's planning and management.

Preparing the ground

The application was well received by the King's Fund London Project Executive Committee, but they stressed the need for Haringey to prepare the ground more thoroughly to enable the development worker to meet the high expectations placed on the post. Haringey agreed to:

- expand its consultation about the project with members, managers, and community organisations, especially the community health council and community relations council, and to seek independent advice from researchers based at the Policy Studies Institute and the South Bank Polytechnic [12]

- establish a policy team which would clarify how the development worker would operate, specify acheivable targets, and discuss the process of evaluation

- begin work on an equal opportunities policy.

Defining the task

These steps were duly taken, and in 1984 the King's Fund approved funding for a three year development post The aim of the post was to 'assist others in the Haringey health services...to develop systems and approaches which recognise and are adapted to the district's multi-racial population'.[13] (See appendix I)

Nirveen Kalsi, a sociology graduate with a background in community work was appointed, and early in 1985 took up her job with a brief to concentrate on five broad areas of activity:

- employment — to work with the personnel department in the development and implementation of Haringey Health Authority's equal opportunities policy

- service provision — to look at those areas of service provision and delivery where there was already an acknowledged need, and to explore others where new initiatives were required, to ensure that appropriate and acceptable services were provided to the black and ethnic minority population

- planning — to help ensure that Haringey's planning process gave adequate recognition to the needs of minority groups by exploring mechanisms by which the groups could contribute to the planning of services

- training and education — to develop a programme of training for health authority members, managers and staff on race awareness and equal opportunities

- information and advice — to act as a resource person, providing information and advice to the authority and its officers on black and ethnic minority issues, and to community organisations on the services provided by the authority.

The ambitious, even daunting, nature of this multiple role was acknowledged. However, all those involved in setting up the project felt that it was important initially that the worker's brief was broad enough to allow scrutiny of all aspects of the authority's operation.

Support for the worker

To provide support and assistance to the development worker, a health care and ethnic minorities steering committee was set up (see appendix II) with the following membership:

3 health authority members
district administrator (later district general manager)
district medical officer
district personnel officer
nurse representative
community health council representative
community relations council representative
King's Fund representative

Structurally, it was agreed that the development worker would be directly accountable to the district administrator (later general manager), as an indication of the status accorded the post and the commitment of the health authority to equality of opportunity and access. As a further indication of status the post was graded at NHS Administrative and Clerical Scale 18, even though there were then very few officers on that pay scale and above in Haringey. The development worker was also to be an active member of several key planning committees, so that the project could make an input across the whole spectrum of management, planning and service delivery.

2. Getting started

The development worker was faced with three initial tasks

- to make herself, her role and the purpose of the project known and understood within the health authority
- to make herself, her role and the purpose of the project known and understood among the many black and ethnic minority community organisations in Haringey
- to organise, at the request of her steering committee, a seminar which would draw together health authority members and officers and community representatives in a constructive discussion about the issues of health, race, equal opportunities and service delivery in Haringey.

It was agreed that throughout the first year the steering committee would meet once a month. The development worker would report her activities and draw upon the members of the committee for advice and support. These regular meetings proved particularly valuable since, in the upheavals following the implementation of general management in the NHS, the worker was left without a direct manager for her first months in post. The former district administrator had taken up a district general manager post elsewhere, and Haringey's new district general manager had not yet been appointed.

The development worker's background was in community work and she had a thorough grasp of the mode of operation of community organisations and the constraints under which they worked. Although she had previously been involved in various health service initiatives as a community worker, she had to develop the skills required to work effectively within the complexities of health service bureaucracy. This was not made easier by the considerable changes taking place within health service organisation and the uncertainties and anxieties which these changes had created among health service personnel. It was in this context that she was required to identify nodal points in the system, develop her formal links and informal networks, and use her inter-personal skills to promote change.

Early problems

While she was sympathetic to the community perspective, the development worker was acutely aware of the responsibilities of her role as an officer, and therefore as a representative, of the health authority. She was also quickly alerted to the ***suspicions and anxieties*** surrounding her post. Community groups thought it might be a 'token' post, a sop from the health authority to placate black

and ethnic minority citizens and create an appearance of action. Some health service personnel felt that, as an agent of change, she would 'create problems' for them, open the door to demoralising criticism of their services, or impose some system of positive discrimination on employment practices.

Only accurate information and constructive dialogue could allay these initial doubts, and the development worker set about meeting and talking to a wide variety of community groups and health service staff. She ascertained the type of information they needed and set about providing it. She arranged for specialist speakers to address groups and organised and passed on health education materials. Where there were obvious gaps in the information available, or where this did not exist in accessible form, she arranged for information packs to be produced and for existing leaflets on, for example, whooping cough vaccination and cervical smear tests to be translated into various community languages.

It quickly became clear that the health authority had ***little systematic information*** about the substantial black and ethnic minority populations of Haringey, and that much of what was available had had been gathered by the district medical officer in preparation for the project itself. Working links with black and ethnic minority organisations and groups were even more tenuous, and tended to be limited to the community relations council and the community health council, neither of which represented the whole spectrum of organisations within Haringey. There was little for the development worker to build on. Taking advice from the local authority community development unit, community relations council, community health council, and social services research unit, she began to identify the various community groups and go out to meet them. She found out where health issues stood on their list of priorities, listened to their needs and perceptions of the health services, and in return provided them with information they required on how the health authority worked and on the availability of specific services.

Community organisations expressed a list of frustrations with the health authority and its services which the development worker recognised from her own community work experience. They included unexplained procedures; unexplained changes in management organisation; impenetrable jargon; lack of information on basic services; and unfair appointment and employment procedures.

As far as the health authority was concerned, those senior officers who had been involved in setting up the project had developed a working knowledge of the issues and sensitivities involved and a commitment to the project's goals. It was clear, however, that this ***awareness and commitment*** had not reached all health authority members and officers, nor had it necessarily filtered through the management structure. Staff, already unsettled by management reorganisation, were apprehensive about the implications of community participation in service planning, and uncertain about what an equal opportunities policy would mean in practice. Much groundwork was needed to raise awareness of race issues. In particular, the development worker had to explain why 'colour-blind' services might not be equally accessible and acceptable to everyone and that more equitable and sensitive services would ultimately mean better services for all.

With the development worker's establishment of sound working links both within and outside the health authority a different worry grew. It seemed to the steering committee that the worker might become seen as the ***sole link*** between the authority and black and ethnic minority organisations, a link which would therefore be viewed as broken were she to leave. The notion of the development worker as sole repository for 'ethnic issues' within the health authority was in total opposition to the ethos of the project, which was to encourage management at all levels to realise their own responsibilities in this field.

In an attempt to counteract any 'sole repository' tendency, the development worker arranged for several senior health authority officers to have independent meetings with community groups. This too proved to have its problems. Groups with a wide range of interests and priorities, often operating in cramped premises and on shoe-string budgets, were in danger of being swamped by the sudden upsurge of health authority interest! They expressed a sense of deja-vu — the development worker was just one of a stream of people including independent researchers and local authority advisors who had already asked them about their needs. What they wanted was to see some positive action. Health authority officers, for their part, were anxious about raising expectations which growing financial constraints might prevent them from meeting. In the end it was decided that, at least for the early stages of the project, it was practicable to have the development worker operating as the main channel for the two-way flow of information.

Early success

The early seminar organised by the development worker — entitled Health Care and the Black and Ethnic Minority Communities — proved useful in drawing together the health service and community aspects of her work. Health authority members, officers and staff and a wide range of community representatives attended. Lord Pitt, with his dual interest in medical practice and race relations, chaired the meeting. The Secretary of the Haringey Community Health Council, Lilias Gillies, spoke about the Haringey linkworker scheme operated by the CHC. Usha Prashar, formerly Director of the Runnymede Trust, spoke about equal opportunities and the health service. Nirveen Kalsi then talked about the project, her own role and its potential. Questions were invited and Lord Pitt summed up, reminding those attending that a seminar putting health care in a multi-racial society on the agenda in Haringey was not an end in itself, only a beginning. Participants expressed satisfaction with the seminar and a willingness to support the project.

On balance, the development worker is convinced that the considerable initial time and effort spent seeking out and gaining the trust of community organisations, bringing them together with senior officers of the health authority, and organising the seminar was well worthwhile. Indeed, it was to prove fundamental to subsequent initiatives which gradually involved communities in the planning process. As a result of these efforts there was increased

management awareness of the range and scope of community groups and of their perspectives. The community organisations' health priorities and interests were clearer, and health authority officers knew which had specific interests, for example in child health, women's health, mental illness or care of elderly people. At the same time community organisations had learned more about how the health authority worked, who its officers were, and what resources were available to them through the health education offices. the role of the community health council was better appreciated. There was a clearer understanding of the relationship of general practitioner services to other sources of primary health care, and the relative spheres of responsibility of the local authority and the health authority.

3. Meeting the goals

The ambitious and wide-ranging goals of the project have already been outlined. By the end of the first year it had become clear that the development worker was at risk of becoming overstretched in attempting to meet all of them adequately. Choices had to be made about which initiatives started as part of the project could safely be handed on to other officers who would take the lead and which areas the development worker should pursue herself.

Employment

During her first year the development worker collaborated closely with the district personnel officer and his senior staff in developing and refining the authority's equal opportunities policy. After overcoming some obstacles, mainly about issues of gender and disability rather than race, the health authority formally accepted the policy in October 1985. (see appendix III) A formal committee, separate from the project steering committee, was established to oversee the implementation of the policy. This included health authority members and officers, representatives from the community health council and community relations council, trade union representatives, a representative from the London Association of Community Relations Councils and the ethnic minorities development worker.

Staff of the personnel department were committed to seeing the equal opportunities policy accepted and implemented. A series of poorly attended seminars organised jointly by themselves and the development worker indicated, however, that the commitment manifest at the top was not shared throughout the management structure. It was obvious that much more work would be needed to ensure whole-hearted implementation of the policy.

In the first year the health care and ethnic minorities committee had spent a great deal of time on details of the equal opportunities policy and were worried that little time had been left to the development worker for other aspects of her brief. With much work still to be done on implementation of the policy, it was evident that the wider goals of the project were unlikely to be achieved. Moreover, the departure from the district at this point of the senior personnel officers who had been instrumental in helping to develop the policy and subsequent staff shortages in the personnel department looked like throwing most of the responsibility for the implementation process onto the development worker.

The steering committee discussed these difficulties at some length. A solution was reached when the new district general manager signalled her commitment to equal opportunities by funding a separate and distinct equal opportunities officer post, accountable to the director of administration and personnel, and responsible for implementing all employment aspects of the equal opportunities policy. An

officer was appointed at the end of 1986 with a brief to cover training, production of a code of practice, and monitoring by ethnic origin of all job applicants and existing employees. (see appendix IV) Links between the posts of ethnic minorities development worker and equal opportunities officer were provided by the membership of the development worker on the latter's steering committee, and by the fact that both steering committees were chaired by the same health authority member. This enabled the development worker to offer both formal and informal support to the new officer.

Service provision and delivery

Following management restructuring in the district, the ethnic minorities steering committee had expanded to include the new unit general manager of district services. The committee had come to feel that the development worker's role now needed focussing to be more effective. The establishment of the separate and distinct equal opportunities post freed the development worker to concentrate more on issues of service delivery.

Debate by the steering committee and consultation with organisations in the community led to the identification of several priority areas for the project, notably services for the growing number of elderly people of black and ethnic minority origin and mental health services. Despite the disquiet that had for some time been expressed by community organisations and by 'front line' health service staff, little mention had been made in district operational plans of a black and ethnic minority dimension in the planning of future services for elderly or mentally ill people. The specific initiatives taken in these areas of service provision will be discussed in detail in the next two sections of this report.

The development worker was also to become involved in the planning and development of a sickle cell and thalassaemia counselling centre, with a management advisory group involving members of the community; a research proposal on appropriate care for terminally ill people in a multi-racial community; a hospital-based linkworker service re-constituted under mainstream funding; and a project to improve services to the housebound elderly.

Planning

Despite her participation in several health authority planning teams and committees, planning proved to be an area of frustration for the development worker. In part this was perhaps due to the disjointed nature of the planning process within the authority; and to the fact that some of the units had yet to take seriously black and ethnic minority health needs. This problem was compounded by the development worker's early concentration on equal opportunities in employment which diverted her from matters of service delivery. The overall result was that the development worker often felt pushed into a marginal role as committee prod or goad on black and ethnic minority issues. Despite her efforts,

consultative planning documents and draft operational plans still failed to mention the needs of minority groups, mentioned them only in passing or as an obvious afterthought.

Discussion with workers from other health authorities indicated that this problem was by no means unique to Haringey, and that in fact Haringey's progress on these issues was rather better than most. At the 1986 conference of the National Association of Health Authorities (NAHA), the vice-chair of Haringey Health Authority seconded a motion (proposed by a Haringey member) that all planning should be required explicitly to take account of the health needs of black and ethnic minority communities. NAHA decided to set up a working party on these issues and the chairman of the Haringey Health Care and Ethnic Minorities Steering Group is a member. Its report was published in November 1988.[14]

In Haringey, though the project's goal of facilitating community participation in planning seemed still to have far to go, the decision to focus upon two particular areas of service delivery was to prove constructive. This helped the development worker to initiate mechanisms by which community representatives could be drawn into the planning processes for two 'care groups'.

Training and education

From the inception of the project, the development worker was involved in a variety of training programmes for health authority members, managers, clinical and administrative staff about the health needs of the ethnically diverse population they served and on how to work towards equality of opportunity. Training was both informal and formal, ranging from discussion groups and seminars to facilitating courses on health care in a multi-racial society and equal opportunities in employment.

Discussions with nurse tutors at the North Middlesex Hospital and Tottenham College of Technology have explored the possibilities of establishing courses to give access to nurse training for people from the black and ethnic minorities who may not have had the opportunity to gain formal entrance requirements, but who display the potential and motivation to become nurses. Though the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) is unwilling to commit itself until two similar 'access courses' at St Thomas's and the London Hospital have been evaluated, the discussions have been positive enough to allow the allocation of funding for a part-time nurse tutor on a future access course in Haringey.

Meanwhile, the discussions have stimulated Haringey's nurse tutors to review and revise the training they offer. They have invited the development worker to address student nurses on a regular basis, and she in turn has arranged for community organisations to contribute to courses. In this way, equal opportunities and black and ethnic minority health issues are now part of the training for one of the largest groups of staff in the health service. The development worker is often asked to supervise or assist in trainee community

nurses' projects, and this in turn has led to other requests for help, for example in reviewing the accessibility of local chiropody services and in drawing up 'action plans' for the newly established localities for managing community health services.

Close co-operation with the district's health education officer has led to the drawing together and dissemination of all available health promotion material — either in community languages other than English, or related to specific health problems such as sickle cell disorder and thalassaemia. Following work done with elderly people from black and ethnic minority communities, the development worker has been co-operating with a team from the London Boroughs' Training Committee to produce a health education video.

Information and advice

Throughout the project, the development worker has continued to fulfil the role of information broker and resource person, providing community organisations with information on the health authority and its services and providing health authority personnel with information about community organisations and the issues affecting black and ethnic minority health. One of her earliest tasks was to compile a comprehensive reading list on issues of health, race and ethnicity.

Because of the innovative nature of the project, the development worker has found herself increasingly consulted by voluntary and statutory organisations interested in particular aspects of health care in a multi-racial society. Other health authorities, within and outside London, have sought advice on setting up similar posts. One of the fruitful outcomes of these contacts has been the establishment, under the aegis of the King's Fund Centre, of regular development worker meetings. These provide mutual support for the sometimes isolated workers, and they facilitate exchange of information and ideas. Another outcome has been the development of an 'ethnic issues' sub-group of the King's Fund Informal Caring Support Unit, and the Haringey development worker has become a member of the National Informal Carers Forum.

This brief outline of the variety of ways in which the development worker set about meeting the goals of the project illustrates the range and scope of the post. It serves to illustrate the extent to which development work is a process — one which involves stimulation of interest, as well as the performance of concrete tasks and skilled interpersonal and committee work on broad front. It is also a pragmatic process, requiring early recognition of what is, and what is not, achievable, of where the areas of 'give' and resistance are within an organisation. It is perhaps the very nature of this process which makes precise, short-term evaluation so difficult in development work.

4. Initiatives in mental health services

Following the steering group's decision to concentrate on two areas of service delivery, mental health services and services for the elderly, the development worker set about increasing her knowledge of existing provision and practice in those areas.

Mental health services were an obvious choice for several reasons:

- for some time there had been growing concern among black and ethnic minority communities about how mental illness was diagnosed and treated by health professionals

- despite this growing concern and the apparent over-representation of black and ethnic minority patients within certain diagnostic categories, the district operational plan made no mention of black and ethnic minority community needs in the planning of future services

- two local psychiatric hospitals, Friern Barnet and Claybury, were scheduled for closure, and the move towards care in the community meant that the health authority would be required to develop a community mental health service. Plans included a range of accommodation and in-patient services, together with day hospitals and community mental health centres. This presented an ideal opportunity to ensure that the needs of black and ethnic minority users were taken into account in the planning of these new community services

- the joint planning team for mental health services (JPT) and a consultant psychiatrist had also expressed disquiet that provision in Haringey was not as appropriate for and accessible to people from black and ethnic minority groups as it was for other sections of the community.

Action plan

The development worker drew up an action plan which involved the following goals:

- review the available mental health services to see whether they were meeting black and ethnic minority needs

- look at initiatives in other areas such as Brent, Lambeth and Bradford
- ensure that black and ethnic minority needs were incorporated into planning for the new community mental health centres and other community care initiatives
- facilitate dialogue between psychiatrists, community psychiatric nurses, other health professionals and black and ethnic minority groups on issues of diagnosis, treatment, and after-care support
- ensure the available information on mental health services in the district reached all members of the community
- involve black and ethnic minority groups in the health authority's planning process.

There was much discussion within both the steering committee and the joint planning team about how best to carry forward the last item of the action plan. There was a clear need for the JPT itself to have better information at its disposal if it were to plan effectively for Haringey's multi-racial population.

Formation of a black and ethnic minorities forum

It was agreed that a sub-group of the JPT would be set up to look specifically at the delivery of services to people from black and ethnic minority communities, and that the development worker would lead this sub-group and be given a free hand in inviting members onto the group. A wide range of members was chosen, representing local authority, research, social work, probation, medical and nursing interests, and including representatives from several community and voluntary groups, the community health council and the community relations council. At this point, the health authority had not yet appointed a general manager for the mental health services. To signal the commitment of the health authority to service improvement, the development worker asked the unit general manager for district services, who chaired the joint planning team for mental health, to act as chairman of the sub-group, and he agreed.

At its first meeting at the end of 1986, the group decided to call itself the Black and Ethnic Minorities Mental Health Forum. It agreed its terms of reference (see appendix V) and decided that as well as commenting upon and feeding into the planning process of the joint planning team, it also wished to establish its own initiatives. These included

- gathering information about mental health services in the district with a view to producing, in several community languages, a guide for users and their families

- investigating the feasibility of setting up a patient advocacy or befriending scheme along the lines of those established elsewhere in London

- investigating the feasibility of establishing an 'ethnic switchboard' to give users or potential users of mental health services advice on mental health problems and where to go for help

- providing better information on the availability of after-care services and support, especially to build links between community psychiatric nurses and black and ethnic minority community organisations

- to design, pilot and carry through a system for monitoring by ethnic origin the users of in-patient psychiatric services, and the kinds of diagnoses made and treatment offered.

The development worker has played a leading role in these initiatives: servicing the forum, providing information to its members; and taking overall responsibility for some of the practical tasks. She has, for example, been instrumental in arranging meetings between the consultant psychiatrist, community psychiatric nurses (CPNs) and various community groups; in assisting the CPNs to produce leaflets on their role and work, and arranging for these to be translated into the various community languages; in putting into effect the in-patient monitoring programme, so that more is known about those who are using psychiatric services — both voluntarily and involuntarily.

Progress

Although it is still in its early stages, the development worker has seen many benefits grow out of the forum, benefits which she has summarised as follows:

- the forum is an important mechanism for planning. In particular it has been successful in bringing together a wide range of individuals, crossing professional boundaries. It has facilitated exchange of ideas between the health authority, local authority and voluntary sector. Members feel that the professionals have at long last begun to listen to service users and to respond in a positive manner

- the forum provides an ideal place for the dissemination of information, thereby increasing the professionals' knowledge of the issues affecting black and ethnic minority users. Further, the voluntary sector has gained by increasing their awareness and knowledge of what services are available and how to use them effectively. This two way process of dissemination of information is the backbone of the forum

- the creation of the forum has established an important point of principle, that of black and ethnic minority groups' participation in planning services. The health authority considers it desirable and valuable to have

users more closely involved in planning services, and the forum provides one model for doing this

- less tangible changes have occurred in the climate of opinion about race issues within the health authority. There is now more direct contact between managers, staff and black and ethnic minority organisations in the district. Managers are more willing to discuss questions of access and appropriateness for ethnic minority groups, and may even raise the questions themselves. Proposals and plans refer more frequently to black and ethnic minority needs

- community organisations have begun to participate more fully and positively in the planning process due to their experience as members of the forum.

In the autumn of 1987 the newly appointed manager for mental health services replaced the district services manager as chair of the black and ethnic minorities mental health forum. With the new manager in post, the development worker, though working closely with her in the early stages, is now in a position to relinquish her central role in the forum. It is perhaps at this point that some of the structural and organisational questions raised by the forum's existence will need to be more fully discussed. It is evident that black and ethnic minority groups have made a very positive input to the forum, but is it in fact a community forum or a professionally-led group with special knowledge and a mission to change services? How does it relate to other management and planning structures? Formally, it is a sub-group of the joint planning team for mental health services, but it has served not only to place policy and planning issues before the JPT, but has itself carried through several concrete activities. How well does it tie in with voluntary sector input into the JPT?

The forum has produced some clear achievements. As community-based mental health services grow and develop, and as the development worker withdraws from her leading role, both the forum and the joint planning team will need to analyse more closely their inter-related roles in the planning, monitoring and improvement of services.

5. Initiatives in services for elderly people

All sources of information predict rapidly growing numbers of black and ethnic minority elderly people in Haringey over the next decade. The development worker's discussions with managers and service providers indicated that very little was known about the health needs of this growing group of potential clients. The assumption tended to be that if they required services then they would come forward to claim them, though it was acknowledged that communication difficulties might inhibit access for those whose first language was not English. Certainly initial impressions were that people from ethnic minority communities were under-represented in, for example, hospital geriatric wards and community chiropody clinics.

Gathering information

The development worker set about trying to obtain systematic information on the uptake of health services by black and ethnic minority elderly people. She attended team meetings of geriatric visitors, health visitors and district nurses, and asked them to assess the numbers of such clients on their lists and to describe any particular issues surrounding their health and treatment. Common themes began to emerge from the discussions, most notably difficulties in communication involving both language and cultural misunderstandings between service provider and client. Associated with these were specific issues, for example failure of clients to take medication as directed; or more general negative feelings, for example that black and ethnic minority clients had 'too high expectations' of the services. Overall, community health staff reported very low numbers of black and ethnic minority elderly people on their books, though it was hard to ascertain whether this was due to their own lack of interest in the monitoring excercise or to genuine under-representation of this section of the population.

The scarcity of basic information at local level was reported back to the health care and ethnic minorities steering committee. They decided that a critical assessment was needed of whom services were reaching, together with an appraisal of the assumptions on which policies, practices and procedures were based. The development worker drew up a plan of action which was presented to the district planning team for the elderly. They in turn agreed to set up a

sub-committee which would look into the issues and report back with a recommendation which could be incorporated into the district's future plans.

The sub-committee comprised the development worker, the district planning officer, the district health education officer, a member of the district planning team who was a lecturer in social policy at the local (Middlesex) polytechnic, and representatives from black and ethnic minority organisations. Thwarted by the lack of concrete information, the sub-committee considered mounting a survey to provide a picture of health needs and patterns of service use (or non-use) before determining how best to improve services. Reservations were expressed about the value of a survey at this sub-committee and by members of the wider steering committee, but the demand for 'hard facts' led to a final decision to proceed.

Surveying need and service use

A small group of members of the sub-committee designed a questionnaire which was brought before the district planning team for the elderly and the development worker's steering group for comments and suggestions. The questionnaire was amended, piloted, and further amended. It covered community, general practitioner and hospital in-patient and out-patient services, and its aims were as follows: to determine the ethnic group, age and sex of respondents; to identify whether respondents could speak, read or write in English; to identify the health needs of the respondents; to identify the health services used by respondents; to determine levels of satisfaction with the services used; to identify possible improvements to the services as suggested by the respondents; and to identify how respondents would like health information to be communicated.

Due to difficulties in defining a random sample of black and ethnic minority elderly people, various community groups were used as a starting point in identifying potential respondents from the major ethnic categories in Haringey. It was decided that interviewers would need to be of the same ethnic origin as those interviewed, and to be fluent in the relevant community language. Funding for eight interviewers to be employed for six weeks was obtained from the Health Education Council, Middlesex Polytechnic and Haringey Health Authority. Training for the interviewers was provided by Haringey's health education department together with the development worker.

A non-random sample of 214 people over 60 years of age were interviewed from the following ethnic categories: Asian (68); Afro-Caribbean (67); Cypriot — Greek and Turkish (59); white English (20). The findings of the survey indicated that the main concerns of black and ethnic minority elderly people were difficulties in communication, inappropriate institutional diets, and a shortage of relevant religious ministers. The main recommendations of the report include the appointment of more bi-lingual staff, the availability of ministers from all relgions, the translation of patient information and better attempts to improve the accessibility of information, for example by using visual and sonal media.

During the course of the survey, Haringey's new service manager for care of the

elderly took up her post. The service manager had both a local authority and community health council background. She was familiar with the role of race relations adviser in the local authority context and sensitive to issues of racial discrimination in employment and equality of access to services. She therefore welcomed the chance to join the health care for ethnic minorities steering committee.

Improving service delivery — specialist nurse visitor

In 1986, as a step towards the improvement of service provision, a joint funding application was made to appoint a health worker for black and ethnic minority elderly people. The development worker saw this as a development post, but community nursing managers wanted to appoint an experienced community nurse and insisted on basing the job description on that standard for a health visitor. Early in 1987 the specialist nurse visitor for the ethnic elderly took up post, accountable to a community nurse manager, and supported by a group comprising: the health authority nurse member; the development worker; the new manager of services for the elderly; the health education officer; and the specialist nurse's line manager. The development worker provided the specialist nurse with her initial training, and continues to provide individual advice and support.

Though much has been accomplished, the effectiveness of this post has been constrained by the diversity of language and cultural groups covered; lack of experience in working with community organisations; and lack of access to the acute sector. It is hoped to establish another joint funded post. It will complement the specialist nurse post, offering multi-lingual and community worker skills, and will focus more on elderly people in hospital, while liaising with the specialist nurse visitor in the community. This second post will be accountable directly to the service manager for the elderly rather than to a nursing manager.

Participation in planning — the black and ethnic minority elderly forum

In the summer of 1987, Haringey took part in a small workshop on services for ethnic minority elderly people organised by the King's Fund and the Standing Conference of Ethnic Minority Senior Citizens (SCEMSC). Haringey was represented by the development worker, the service manager for the elderly, a consultant geriatrician and by members of the several community organisations

already involved in assessing and planning services. Discussion at the workshop helped to crystallise ideas about how to move forward and subsequently the service manager presented to the health care and ethnic minorities steering committee a list of short-term and medium-term actions which could be implemented to improve services for black and ethnic minority elderly people in Haringey. (see appendix VI)

To co-ordinate information, planning and action, the development worker and service manager proposed to establish a black and ethnic minority elderly forum, along the same lines as the mental health forum. This would replace the ethnic sub-committee and be a sub-group of the new local authority and health authority joint planning team for the elderly. It would be chaired by the service manager, and its membership would include representatives from black and ethnic minority community organisations, as well as from the local authority, health authority and voluntary organisations usually associated with planning for the elderly. The forum was launched in the summer of 1988.

Thus for both mental health services and services for elderly people, a 'forum model' has come to provide the arena for involving black and ethnic minority groups in reviewing and planning services. In the case of mental health services, the establishment of a forum generated initiatives, and in the case of services for the elderly, it provided the format for bringing together a number of existing independent initiatives. Although reached by different routes, and contributing to different services, this format raises similar issues for the future as the development worker relinquishes the leading role to service managers. How well will the forums relate to joint planning teams? What is the relative 'weighting' of community representation on the forum compared with professionals and managers? Where do its black and ethnic minority representatives stand in relation to other voluntary groups participating in joint planning teams? As the process of community participation in service planning develops, these and other questions raised by the forums will require closer analysis.

6. Moving on

By the end of 1987, the project had almost completed its first three years, and the health authority needed to assess what had been achieved and what remained to be done. Effective change takes time. It is often stated that large-scale, complex organisations, such as the national health service, with vested interests and established working practices, tend to have built-in inertia. This is particularly true when the changes concern sensitive issues such as those of race and racism, community participation in planning, and equality of opportunity and access. Health authority officers had already been obliged to adjust to management reorganisation. Had they been able to respond fully to the issues raised by the ethnic minorities development worker? How far had responsibility for ensuring equality of opportunity in employment and service delivery been taken seriously by managers in the new structure?

In one sense it was the objective of the development worker, as it is for those in most development posts, to work her way out of the job — to encourage managers to take responsibility and action and then to move on. Though commitment had become increasingly manifest at top and middle management levels in the authority, there still appeared to be blocks lower down the management heirarchy. Moreover, the bulk of the development worker's input had been with the priority care services. Much still remained to be done in the acute sector.

Consideration had also to be given to the position of the development worker herself. Over the three-year period she had become a useful and valued member of the district team. Senior managers were loath to lose her experience, while not wishing to deny her the opportunity for personal career progression.

For all these reasons, an application to continue the project was made to the King's Fund at the end of 1987. The health authority proposed to meet half the costs of the development worker post for a further year if the King's Fund would supply the other half. The health authority would provide management training and experience and at the end of the extension year would consider the possibility of a permanent appointment. This was agreed, and the post has now been extended until early in 1989.

Tackling the acute sector

A new unit general manager for acute services came into post in 1987. He was keen to see that equal opportunities in employment and equality of access to services should become integral to management in his unit. Discussions between the development worker, the district general manager and the new unit general manager sought to identify priority areas within acute services to be tackled by the development worker.

At the same time, the development worker still had a role in carrying forward initiatives by the mental health forum and the forum for the ethnic elderly. The decentralisation of community health services into four 'localities' had also created increased opportunities for cooperation between health service and local authority personnel and local community organisations. The development worker saw the need, therefore, to work closely with the new locality managers and the senior community nurse managers.

During the term of the project, funding had ended for the team of linkworkers managed by the community health council. Based at the North Middlesex Hospital, but operating in both the hospital and community, this multi-ethnic, multi-lingual team of interpreters/patient advocates had provided a valuable service. Despite increasing financial constraints, the health authority recognised and was encouraged by community groups and health service managers to accept the contribution made by the linkworkers, and in 1987 the scheme was re-constituted on mainstream funding. However, the number of linkworkers was reduced and they were, initially at least, to be limited to working within the North Middlesex Hospital.

As a key aspect of her move into the acute sector, and to develop her management skills, the development worker has taken over ***management of the linkworker team.*** Her role will be to ensure that the scheme is widely known and, more importantly, widely used. At present the major user of linkworkers is the maternity department, which is where the scheme began in Haringey. Managers are keen that wards for children and elderly people make more use of linkworkers. There is also an evident need to have linkworkers again available to community services and the development worker is involved in seeking additional funding to make this possible. There is still a tendency for clinical staff to see linkworkers as providing a primarily interpreting service. The development worker will help to work out a strategy to promote understanding and use of the linkworkers' skills in advocacy.

To ensure that acute services are appropriate and accessible to all sections of the community, managers and staff must be committed to achieving equality of opportunity and must be suitably trained. The development worker will provide ***training for senior managers*** in the acute unit to ensure that they understand the need for and the purpose of work on equal opportunities in employment and equality of access to services.

Professional bodies for NHS staff are only now beginning to recognise that training must take into account the needs of a multi-racial population. The development worker will continue to collaborate with training officers, nurse tutors and others to assess what changes are necessary in basic and post-basic curricula. This is particularly important for staff who provide direct patient care. To improve service quality, training must cover communication skills; the questioning of established assumptions and practices; and the elements of good practice.

The development worker will continue to assist the school of nursing and the Tottenham College of Technology to plan an access course to nurse training.

The development worker will become a member of the health authority's committee on ***quality assurance*** which will choose particular departments or issues for her attention. The aim will be to help managers identify how standards of service to individual patients can be enhanced and to highlight examples of good practice.

It is recognised that the training needs of ancillary staff employed by the health authority have been neglected. The development worker will collaborate with the assistant director of quality assurance in drawing up a training programme for ancillary staff to help them progress. Areas already identified are assertion training and literary and numeracy skills.

7. Lessons learned

In late 1987, a seminar on the health of ethnic minorities in Britain was held by the DHSS with Mr Tony Newton, Minister for Health and Chairman of the NHS Management Board, taking the chair.[15] Copies of a report on the seminar were widely circulated by the Department. In his covering letter, headed The Management Challenge of Ethnic Minority Health, the Minister affirmed that 'the Government is unequivocally committed to the principle of equal opportunities both in employment in the NHS and in service delivery'. He further stated that he looked to 'Districts, Special Health Authorities and the Family Practitioner Committees for action', while the Department for its part was 'keeping this subject in mind as a possible performance review item.' What lessons can be drawn from the Haringey project for those health authorities wishing to go forward in meeting the challenge?

Pace of change

Establishing an equal opportunities policy, let alone getting it fully implemented, can take longer than anticipated, with unforseen setbacks along the way. Similarly, changing patterns and methods of service delivery, and setting up structures through which the views of service users can be incorporated into the planning process can be lengthy tasks.[16]

Community organisations and health service managers can have quite different perspectives on the time-scales involved. Community groups, impatient for change, can become frustrated by the early lack of visible results, and this can lead to accusations of 'token' appointments, 'the appearance of activity', and 'marginalisation' of the issues. To community activists the health authority processes — set up a sub-committee, carry out a survey — can look like recipes for delayed action. Health service managers of the 1980s, on the other hand, sometimes feel almost swamped by the number and scale of changes and impending changes with which they have to contend. They feel beset by financial constraints. They want time — to become better informed, to be consulted, to assess budget implications. There can also of course be more trenchant resistance. Both management and staff may wish to avoid facing up to the uncomfortable issues surrounding health, race and inequality. They may prefer to cling to the notion that a 'colour-blind' service is by definition an equitable service and may wish to deny evidence which makes it clear that this is not so. There can be marked resistance to altering established practices in employment and promotion and a refusal to accept that these practices may be discriminatory.

In this context, the background of the 'agent of change' can be an important issue. Those with health service experience will understand how the health

service works, what sort of constraints operate, and where there are opportunities for change. With luck, they may already have developed the skills necessary to carry management along with them. They may well, however, lack a deep understanding of just who community organisations represent, and how, and under what sort of constraints, they operate. Unwittingly they may be blinkered by a health service perspective. Community workers, on the other hand, will know what the issues are 'out there' in the community. They will know how to develop the necessary community links, and how to avoid the pitfalls of factionalism. But they will have to learn, and will probably share the communities' frustration with, the often ponderous workings of the health service bureaucracy. They may find themselves isolated or misunderstood, identified by health service officers as working for the community rather than for the health authority.

In the Haringey project, the balance turned out to be about right. The development worker's background in community work allowed her to understand the perspective of community groups, and gave her credibility in their eyes. At the same time, her refusal to become personally involved in particular case histories, always referring them on to the manager responsible; her relatively senior status within the health authority hierarchy; her direct line of accountability to the district general manager; and her inter-personal skills and organisational insights gave her credibility in the organisation which employed her.

Management of change

This leads to the question of how change is managed. Early anxieties about the Haringey development worker post which were expressed by health service officers and staff centred around fears of being 'told what to do' by vociferous and critical members of the black and ethnic minority public. What would community participation in planning really mean? Was an equal opportunities policy positive discrimination by a different name?

Despite strong community representation, the health care and ethnic minorities steering committee has continued to be led by health authority members and managers. This fact, and the decision of the new district general manager to take a full and active role in the committee, has undoubtedly encouraged other managers and officers to 'own' black and ethnic minority health issues. This is not to say that a 'top down' approach does not need to be counterbalanced by grassroots, 'bottom up' impetus. In an organisation as hierarchical as the health service, however, and with a post which could conceivably be pushed to the periphery of the organisation's concerns, backing at this level is essential.

The mental health forum and the forum for the ethnic elderly have undoubtedly opened up avenues for community participation in the planning process which did not exist before. That being said, even these notable achievements of the project have not been without inherent tensions. Differences in community and management perspectives on the role of the forums have not yet been fully

discussed and resolved. Some managers feel that the groups are too 'task oriented' and that they are trying independently to respond to issues which they should be persuading the joint planning teams to take on board. On balance, however, these forums have been the project's most visible successes in getting the community working together with managers.

Position of the development worker in the organisation

The location of a development worker within the organisational structure is a key issue. The Haringey post was funded from outside, with a fixed term of appointment, and not attached to any particular department, conditions which might push an inexperienced development worker with weak support systems into a peripheral role. Despite the development ethos, which insists on the ultimate responsibility of managers, they could well end up acting as sole repository for black and ethnic minority issues within an authority. In Haringey, a central location at the district headquarters; the support of the district general manager, senior officers, and the authority member who chaired the steering committee; plus the development worker's own interpersonal skills have all prevented this from happening.

The 'free floating' nature of a development post can, on the other hand, be put to positive use as it was in Haringey. It enables the development worker to operate at any point of the heirarchy in a way not readily open to other health authority officers. It can also enable the worker to identify the points in the system and the individuals most open to influence.

Process and pragmatism

It was fortunate that the health care and ethnic minorities steering committee acknowledged early enough the near impossibility of combining development worker and equal opportunities officer roles in one post. The commitment indicated by the authority in finding mainstream funding for a separate equal opportunities officer, located in the personnel department, has undoubtedly helped to untangle potential difficulties. Moreover, as two relatively senior officers working on inter-related issues, the development worker and the equal opportunities officer have been able to enjoy a mutually supportive relationship.

Support outside the health authority has also been helpful. In the case of the Haringey Project this has been provided by and through the King's Fund Centre, by means of regular meetings with workers doing similar jobs in other health authorities.

In the end, only the determination of a health authority to promote equality of opportunity and access can ensure success. A young personnel officer from

Haringey, having attended her first equal opportunities training seminar, was heard to exclaim with relief 'it's just good personnel practice!'. Perhaps the necessary determination will come about as more health authorities begin to acknowledge that meeting the needs of their black and ethnic minority populations is just good health service practice.

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Appendix I

HARINGEY HEALTH AUTHORITY
JOB DESCRIPTION

Title	Development Worker (Ethnic Minorities)
Grade	Scale 18
Salary	£10393 £12615 + London Weighting £623 per annum
Conditions	Whitley Council Conditions of Service
Term	This is a 3 year development post aimed at assisting others in the Haringey Health Services (heads of departments, service providers) to develop systems and approaches which recognise and are adapted to the District's multi-racial population. At the completion of the project the need for a continuing specific commitment of staff and time may or may not be demonstrated. This post is intended as a 'pump primer', rather than one with a specific long term workload. Funding for the post has been provided by the King')s Fund London Project and copies of the submissions made to that body are attached.
Accountability	To the District Administrator.
Liaison with	The postholder will have strong links with the District Medical Officer who jointly sponsors the project.
Manages	P.T. Secretary.
Duties	1. The Development Worker will be responsible for the development of an action programme within Haringey Health Authority which will involve the identification of the issues involved in each of the four major areas of the Authority's activities as detailed below, and will work with District staff to develop appropriate programmes for tackling these issues. An important aim will be to ensure that the programmes are regarded as integral to the work of the Health Authority and its various departments. The worker's role will be to work with managers and staff in the NHS in Haringey in order to: — encourage in managers and providers awareness of Haringey's multi-racial population and its needs. — assist managers and providers to identify initiatives in each of the main areas identified below. 2. The four areas of activity are: — *Service provision and delivery* To identify the initiatives needed to ensure that appropriate and acceptable services are provided to ethnic minority groups and that uptake to these services is improved. — *Planning* To help develop the Districts planning process to ensure it is suited to a consideration of the needs of ethnic minority communities. One aspect of this will be to develop links with minority groups in order to allow input from them into the process of developing services.

— *Employment*

To develop the concept that the Health Authority, as a major employer, should commit itself to setting an example of equal opportunity in employment.

— *Training and Education*

To promote the training of managers, supervisors and staff in adapting to the needs of a multi-racial workforce and in delivering effective health care in a multi-cultural setting. Training will mainly centre on the raising of consciousness and understanding about the needs generated by a multi-racial community. Some education on practical aspects such as service initiatives successful elsewhere will also be provided.

3. Priorities have been identified for the first year of the project.

a) Equal opportunities policy — development and implementation.

b) Service provision.

— ante-natal and obstetric services (linking with initiatives already being undertaken by the Community Health Council funded by the Manpower Services Commission). It is felt useful to commence with work in an area where there is an acknowledged need and where there is already some work going on.

— services for the elderly people from ethnic minorities. The issues raised by ageing in the ethnic minority population are only just coming to the fore in Haringey.

c) Planning.

— Haringey District and Borough are involved in a major planning and development task to develop locally based community orientated psychiatric services and allow the closure of two large psychiatric hospitals. The local services developed must reflect the racial and cultural diversity of the community served.

d) Training.

— The priority will be to develop a programme of Race Awareness Training, beginning with senior members of staff and authority members, but including 'shop window') staff such as receptionists and indeed other key staff such as heads of departments. Trainers within the District will be given the opportunity of acquiring the techniques of race awareness training.

Priorities will be reviewed during the course of the project. Further strategic objectives in the field of health care and ethnic minoritie will be set during the final period of the project.

4. The Development Worker will act as a resource for the authority and its officers in the provision of information and advice on ethnic minority issues.

5. *Organisational Framework*

5.1 A steering committee has been established with the following membership

— 3 members of the DHA

— District Administrator

— District Medical Officer

— District Personnel Officer

— Nurse representative

— Representative of the Community Health Council

— Representative of the Community Relations Council

In structural terms, the worker will be accountable direct to the District Administrator and will be supported by the steering group, whose core is members of the DHA and DMT. In the priority tasks, the worker will gain entry to the organisation as follows

Equal Opportunities —	District Personnel Officer and Personnel network
Obstetric services —	Maternity Services Action Group
Services for the Elderly —	Elderly Planning Group
Mental Health Planning —	District Medical Officer and Mental Health Planning Team
Training —	Training Officer and Nurse Personnel Officer

Entry to the organisation will also be be working with staff members already committed and involved in ethnic minority health issues.

The worker will be a member of the Senior Administrators Group.

5.2. The Development Worker will also be expected to develop links with relevant community groups and organisations, the Community Relations Council, the Community Health Council and appropriate officers of the London Borough of Hackney.

6. Documentation and Evaluation of the Project

The postholder will be expected to document progress periodically for the steering group. She/he will be expected to complete the assignment with a substantial report on the major issues facing Haringey Health Authority when the project began, an account of his/her activities and of progress achieved, and proposals for future action.

7. Qualifications

The successful applicant will be suitably qualified, probably a graduate, with experience in some of the following areas

— Community relations

— Local Government social services

— Social Science Research

— The organisation of voluntary social support agency of some kind

— Personnel management

7. The successful applicant will be someone with an understanding of the cultures and traditions of the members of the various races who are served by the Health Authority, and some insight into the needs of the communities. He/she must be able to co-ordinate the

development of the programme and be capable of negotiating positive action commitments within the district, working with senior health authority staff, involving community and voluntary organisations and relating to ethnic groups.

However, the prime object is to secure the services of a committed and dynamic worker who can at the same time exercise considerable tact in a very sensitive job.

April 1984

Appendix II

HARINGEY HEALTH AUTHORITY
Health Care and Ethnic Minorities Steering Committee

Terms of Reference

1. **Objectives**

   a) To propose policies for adoption by the authority, to find ways and means or achieving them, and to monitor their implementation and effective working.

   b) To ensure that all staff of the authority are aware of and understand the policies adopted by the authority.

   c) To ensure that all staff co-operate with the Ethnic Minorities Development Worker in her work.

2. **Support the Ethnic Minorities Development Worker**

   a) The Health Care and Ethnic Minorities Steering Committee will receive advice on policy matters from the Ethnic Minorities Development Worker and to discuss and adopt these as appropriate.

   b) The Health Care and Ethnic Minorities Steering Committee will support the work of the Ethnic Minorities Development Worker in raising the awareness of managers on issues concerning the Black and Ethnic Minority Communities, with particularly references to service provision and delivery, planning, employment and training.

   c) To increase the level of participation and consultation of black and ethnic minority groups in the planning of services and their provision and to monitor that this is achieved.

   d) The Health Care and Ethnic Minorities Committee will offer advice on monitoring and work alongside the Equal Opportunities Policy Group.

NK/CR
August 1986

Appendix III

PD(P) 1
Agreed by DMT 11/4/85
Agreed by DJSC 19/6/85
Agreed by DHA 11/9/85

HARINGEY HEALTH AUTHORITY

EQUAL OPPORTUNITIES POLICY

1. Introduction

1.1 The purpose of this policy is to affirm the authority's commitment to the establishment and development of equal opportunities in employment. This is in recognition of its role as an employer in a multi-racial society and one of the main employers in the community it serves.

1.2 In the promotion of its policy, the authority will endeavour to meet in full the statutory requirements of the Race Relations Act, the Sex Discrimination Act, the Codes of Practice relating to these and the measures relating to the employment of disabled persons.

1.3 The authority accepts that the principle of equal opportunities is fundamental to good employment practice, and, used to full effect, will ensure maximum utilisation of the potential and current resources of those employed within the organisation to their benefit by providing them with the opportunity for development and to the benefit of the service through the most effective use of its manpower.

2. Statement of Intent

2.1 It is the authority's aim to be an equal opportunities employer. In the pursuit of this goal, the authority will, through the District Personnel Officer, undertake positive measures to ensure no present or future employee is directly discriminated against by being treated less favourably on grounds of sex, race, creed, nationality, ethnic or national origin, marital status, sexual orientation, disability, culture, religion or social background; or indirectly through the application of a condition or requirement which cannot be shown to be justified.

2.2 The authority will also actively seek to discourage discrimination by victimisation of any individual reporting an incident of discrimination.

2.3 As part of implementing the policy, regular reviews of policies and procedures (i.e. recruitment, disciplinary, grievance, redundancy etc) will be undertaken to ensure:

a) that they accord with the principle of equal opportunities, and,

b) that there is consistent and objective application across the whole employment field, with individuals being selected, promoted and treated on the basis of their relevant merits and abilities.

c) guidance notes on the operation of the various policies and procedures (i.e. advertising, recruitment and selection, grievance, disciplinary, redundancy etc) will be issued.

2.4 This policy applies to all present and future employees: to make it fully

effective positive action will be taken, where appropriate and practicable, to encourage and train individuals to progress within the organisation.

3. Action

3.1 While the authority, through the District Personnel Officer, accepts overall responsibility for implementing and monitoring the policy, there is an obligation on employees and trades unions to co-operate in the adoption and furtherance of equal opportunities.

3.2 The authority undetakes to communicate to all employees through the various media available, its intent to follow a programme of equal opportunities. Also to make it known to the wider community that its aim is to be an equal opportunities employer.

3.3 The authority undetakes to make it known to employees the obligation placed on them, in particular by the Race Relations Code of Practice and the Sex Discrimination Act Code of Practice to:

a) co-operate in measures introduced by management to ensure equal opportunities and non-discrimination in the employment field; and

b) where such measures have not been introduced, press for their introduction (through their union where appropriate); to

c) draw the attention of management and where appropriate, their trades unions to suspected incidents of discriminatory acts or practices; to

d) refrain from harrassment or intimidation of other employees on grounds of race, sex, sexual orientation, disability etc, for example, by attempting to discourage them from continuing employment.

3.4 The codes of practice also recognise an important role for trades unions in preventing unlawful discrimination and in promoting equal opportunities and good race/industrial relations. The codes state that trades unions should encourage and press for equal opportunity policies so that measures to prevent discrimination at the workplace can be introduced with the clear commitment of both management and unions.

3.5 To this end a subcommittee of the District Joint Staff Committee has been established with a remit which includes consultation, negotiation on the policy and its future operation.

4. Advertising policy

4.1 It has always been the aim of the authority to reach as wide a recruitment field as possible. However, positive steps must be taken to bring the authority's vacancies to the attention of minority and disadvantaged groups.

4.2 Bearing in mind the possible restrictions resulting from the recent advertising scrutiny in the health service, the authority will be revising its internal bulletin with a view to using it as a direct means of approach to identified ethnic and minority groups in the community as well as a means of informing staff of current vacancies.

4.3 This bulletin will be in addition to external advertisements. Both will incorporate a statement of the authority's aim to be an equal opportunities employer.

4.4 Guidance notes will also be produced to ensure measures are taken to avoid 'word of mouth' or 'direct approach' recruitment which adversely affects the

equality of employment opportunity.

5. Employment policy

5.1 The authority is currently reviewing its recruitment policy. There will be a redesign of the application form in line with this which will incorporate a monitoring sheet.

5.2 One of the aims of the recruitment policy will be the establishment of job descriptions and personnel specifications which are job related.

5.3 Procedures on shortlisting will be established which will ensure that there are at least two officers undertaking this task (one being a personnel officer or another officer fully trained in the equal opportunities policy and delegated to act in the role of shortlisting officer by the appropriate UMT or DMT). Other shortlisting officers will be made fully aware of the criteria to be applied and the need for consistent application. Forms to record reasons for non-selection will be made available for completion and returned to the personnel department.

5.4 Selection criteria will be established that do not discriminate and can be proved to be a requirement for the safe and effective performance of the job or clearly demonstrable career pattern.

5.5 Guidance notes on the conduct of interviews will be prepared for use as will interview assessment forms which will also be used for recording the result of the interview.

6. Training and promotion

6.1 All steps will be taken to ensure equal access to opportunities for promotion and training.

6.2 There is a vast area of training to be considered in the light of equal opportunities. In the early stages of implementation, training and guidance will be given to all staff in key decision making areas to make them fully aware of their responsibilities in this field.

6.3 Training for the senior officers of the authority will also be instigated to increase their awareness of their role and the implications of the policy.

6.4 Incoporation of an equal opportunities module in the authority's induction and management training programmes will be undertaken. Employees' attention will be drawn to training opportunities as they arise.

6.5 Areas of training will include

i) recruitment and selection training for staff responsible for appointments

ii) training in racism awareness

iii) sex sensitivity training

iv) disability sensitivity training

v) communication and language training for which close links will be established with local institutions providing training in this field

vi) induction training of new appointees

vii) management training

viii) training for 'shop window' staff

ix) training in the various policies and procedures (i.e. grievance, disciplinary etc)

x) training for promotion (resulting from identified training needs)

6.6 Wherever possible and practicable, advantage will be taken of the provisions in the acts for positive action.

6.7 The authority will be looking to the various community and training organisations to assist in this field bearing in mind the limitations of its budget.

7. Cultural and religious needs

7.1 Measures will be taken to ensure that existing policies, particularly those on uniform, are modified to accommodate cultural and religious needs wherever they are compatible with the safe and efficient running of the service.

8. Disabled persons

8.1 The authority will aim to achieve the statutory quota for registered disabled people and attempts will be made to overcome some of the practical difficulties that exist and thereby enhance employment opportunities for disabled people. The authority will seek the close co-operation of the Disablement Resettlement Officer in this matter.

8.2 The authority does, however, recognise that many disabled persons choose not to register as disabled. It will seek to ensure all disabled persons, whether registered or not, are aware that they will receive equal treatment and they will be considered solely on their ability to do the job.

9. Terms and conditions

9.1 The Whitley Councils set the terms and conditions under which staff are employed and these are nationally negotiated with the various trades unions and staff organisations. There are provisions within the General Whitley Council for equal application of terms and conditions in respect of staff and this will be carried out consistently and objectively.

10. Annual leave procedure

10.1 Annual leave provisions are nationally negotiated and are part of the Whitley Council agreements. The authority will, however, show consideration to requests for unpaid leave for employees to visit relatives overseas, where this does not adversely affect the safe and effective operation of the service.

11. Disciplinary procedure

11.1 The authority will consider seriously and investigate fully reported incidents of sexual, racial or other harrassment.

11.2 The disciplinary procedure has been revised and modified to incorporate consideration of the following:

a) racial abuse or other racial provocation

b) communication and comprehension difficulties

c) the employees' differences in cultural background and behaviour

Where incidents of discrimination come to light they will be viewed as serious misconduct and appropriate disciplinary action will be taken.

12. Grievance procedure

12.1 All employees have the right to seek redress for their grievances.

It is recognised that employees often find it difficult to approach their immediate superiors in cases of discrimination. It is therefore proposed that the first point of contact in incidents of this nature should be the appropriate personnel officer (or administrative officer in the case of personnel staff). If the individual remains aggrieved then a formal complaint in writing should be made to the appropriate administrative officer.

13. Monitoring

13.1 In order for the policy to be effective (i.e. that aims set are being achieved) and to allow the authority to identify areas where positive action is required, monitoring of the composition of applications for posts and the current workforce will be undertaken.

13.2 Monitoring will involve:

a) the collection and classification of information regarding the ethnic origin, sex and disability of all current employees and job applicants.

b) the examination of ethnic origin, disability, sex, and sexual orientation of the distribution of employees and the success rate of applicants according to grade, job category, department on a unit by unit basis over a period of time.

c) recording, recruitment, training and promotional records of all employees, the decisions reached and the reason for those decisions.

d) an assessment of the extent to which the distribution and promotion rates reflect equal opportunities for all groups, and if appropriate, review policies and procedures in consultation with trades unions in the light of this.

13.3 The authority wishes to stress that this information is purely for the purpose of ensuring the effective implementation of its equal opportunities policy and will be kept in strictest confidence in the personnel department.

October 1985
DEFB/KM
A:U1:EOP

Appendix IV

HARINGEY HEALTH AUTHORITY

JOB DESCRIPTION

Job Title	Equal Opportunities Officer
Grade	Scale 14 £11,551 to £13,899 inclusive of London Weighting
Responsible to	Director of Administration and Personnel
Statement	Haringey Health Authority is committed to the establishment, development and implementation of equal opportunities in employment for all regardless of 'sex, race, creed, colour, ethnic or national origin, marital status, sexual orientation, disability, culture religion or social background'. Also to the elimination of practices and procedures that would limit the employment prospects within the authority of current and future staff. The authority recognises the importance of good employment practice as a corner stone for the effective delivery of service to the multi-racial community which it serves, and will aim to ensure that its policy is implemented in a manner reflecting the diversity of the population of the area it covers.
Job summary	The Equal Opportunities Officer will advise the authority and its officers on all matters relating to equal opportunities and will assist the District Personnel Manager in implementing the authority's policy. The postholder shall have access to all levels of management in order to ensure the effective performance of the duties required.

Duties and responsibilities
POLICY DEVELOPMENT AND PROMOTION

1. To act as adviser to the authority and its officers on all equal opportunities issues. This will include the identification of areas of concern, the development of strategies to deal with those areas and ensuring the implementation of agreed plans.
2. To attend meetings of the District and Unit Management Advisory Boards when items with a major implication for equal opportunities are being discussed as requested by the District General Manager, and present bi-annual progress reports to the authority via the District Management Advisory Board.
3. To advise on the implications of law and good practice as it relates to equal opportunities.
4. To act as Secretary to the authority's Equal Opportunities Policy implementing committee.
5. To represent the authority at meetings of the King's Fund Equal Opportunities Training Forum.
6. To develop research initiatives in relation to equal opportunities aspects of the authority's work and promote positive action programmes.
7. To review annually, in line with developments, the Equal Opportunities Policy, and other policies and procedures to ensure they accord with the aims of the policy.

8. To liaise with managers in the design of action plans for equal opportunities development in their departments.
9. To establish links with local community groups, the local borough council, trade unions, NHSTA and other bodies concerned with the development and promotion of equal opportunities and seek to involve them in the development of the authority's policy.
10. In conjunction with the ethnic development worker, to actively promote the authority's policy in the community.
11. To identify and investigate possible sources of funding to assist in the implementation of the authority's policy.

EMPLOYMENT

1. To develop in conjunction with personnel officers, detailed programmes of action to promote equality of opportunity in employment within the authority, including the identification and promotion of schemes designed to remove unnecessary discriminatory barriers in the employment training and promotion of staff within the authority.
2. To develop, in conjunction with personnel officers, monitoring systems (including record keeping) to establish the effectiveness of the programmes and policy.
3. To participate, on an ad hoc basis, in the shortlisting and interviewing of staff to ensure that an objective and consistent application of the policy is carried out. To participate in ensuring that job descriptions meet the policy's requirements.
4. To develop, in conjunction with the personnel officers and the District Training Officer, training strategies and programmes for staff and to participate as a direct trainer appropriate.
5. To work with the ethnic development worker in ensuring employment practices result in sensitive service delivery.

The postholder is required to undertake their duties with due regard to the principles and aims of the authority's equal opportunities policy.

Qualifications/Experience

Relevant experience of equal opportunities policy and community work would be an advantage.

The ability to communicate clearly and to work on their own initiative on complex and sensitive issues is more important than formal qualifications alone.

NB: This job description will be reviewed with the postholder within a mutually agreed period of time.

Appendix V

HARINGEY HEALTH AUTHORITY

BLACK AND ETHNIC MINORITIES MENTAL HEALTH FORUM

TERMS OF REFERENCE

Objectives To assess and plan for equality of access and care for all users of the mental health services.

Tasks

1. To review existing services.
   - 1.2 To find out the ethnic composition of mental health users.
   - 1.3 To identify the admission patterns of users of mental health services.
   - 1.4 To find out the ethnic composition by diagnosis.
2. To identify patterns of treatment by ethnic origin for the main categories of diagnosis.
3. To identify the discharge pattern of mental health users and support services provided.
4. To identify alternative sources of care/help used by the community.
5. To identify ways of improving access and care for mental health users in the outcome of the above.
6. To review and monitor progress.

NK/CR
October 1986

MEMBERS

Mr Henderson Holmes —	Haringey Social Services
Mr Val Teloka —	Haringey Social Services
Mr Andy Bishop —	Middlesex Area Probation Service
Mr Mike Zamora —	Mental Health Relatives Support Group
Afrendra Eleftheriou —	Haringey Greek Women's Health Group
Ishi Harbott —	Asian Women's Forum
Maureen Royal —	Walk In Centre — Turnpike Lane
Mr Sam Amponsah —	Community Psychiatry Nurse
Dr W.G.Smith —	Consultant Psychiatrist
Dr A.G.Griew —	Director of Community Medicine
Mr Geoff Smith —	Unit General Manager — District Services
Ms Nirveen Kalsi —	Ethnic Minorities Development Worker
Mr Omar Ralph —	Haringey Community Relations Council
Mr Dennis Bradley —	Haringey Community Health Council
Ms Afrakuma Bannerman —	Psychotherapeutic Counsellor

Appendix VI

HARINGEY CONTRACT
Outcome of a workshop held at the King's Fund Centre on 10 June 1987

Short Term

1. 'Balance of Care' research — should have a stronger element of considering and planning to meet the needs of black and ethnic minority communities.
2. Health Authorities should notify community groups of any new initiatives, with regard to ethnic minority issues e.g. appointment of workers.
3. 'Who's Who' within each authority to be exchanged and widely distributed.
4. To set up a forum where authorities and organisations can meet — this might be related to service areas and joint planning.
5. King's Fund to disseminate information from the workshop to local authorities and participants.
6. To develop a strategy to provide interpreting and translation services.
7. To ensure that staff within the health services and voluntary organisations have been made aware of the Equal Opportunities Policy and to raise EOP with a view to developing good practice guides.
8. Development by Local Managers in Community of strategies to liaise with GPs and voluntary organisations in the area.
9. To 'put together' a 'fly sheet' for general managers of the issues, for inclusion in management agenda to lead to the inclusion of specific issues in short term programmes.

Medium Term

1. Effective consultation and participation mechanism to be up with community groups (following point 4 of Short Term list), and to bring into effect regular meetings.
2. SCEMSC to develop a newsletter with the King's Fund to relate initiatives and events and resources at a national level.
3. Head count of black and ethnic minority patients in hospital to determine:

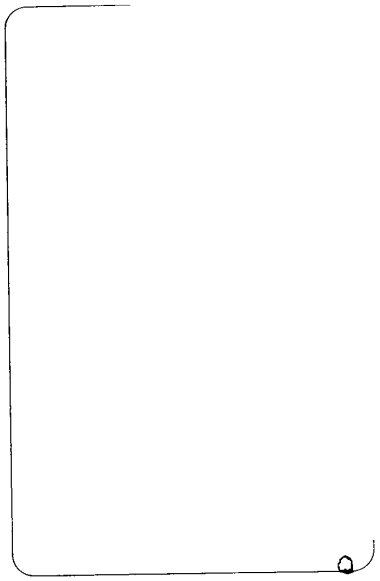
   a) how long they have been admitted;

   b) any intention of discharge.
4. To develop a scheme of paid volunteers to befriend people in hospital and to befriend them following discharge.
5. To set up screening clinics with interpreters geared to black and ethnic minority communities, with the provision of transport.
6. Structures to be established by Locality Managers to liaise with voluntary organisations and GPs (following Point 8 of Short Term list).

Long Term

1. To develop positive policies and initiatives as a result of consultation and meetings.
2. To allow the realisation of, and to resolve adequately, the strategy of provision of interpreting and translation services, and advocacy.

ADG
June 1987



This is the story of a King's Fund project and of the attempts of one London health authority, Haringey, to improve the services it offers to its multi-racial community.

With support from the King's Fund, Haringey approached the challenge by appointing an ethnic minorities development worker. It has been this worker's job to help to develop an equal opportunities policy; to provide education, training, information and advice to health authority staff and to the wider community; to review the appropriateness of services and their accessibility to Haringey's black and ethnic minority communities; to help managers develop policies and implement change; and to begin the process of involving black and ethnic minority groups in planning services.

Three years into the project, it is possible to review some of its achievements and some of the questions it has raised. Development work is very much a process. Results are often long-term, input and innovation takes place at many points in the structure and outcomes may be difficult to evaluate precisely. This report does not therefore provide a detailed analysis of the role of development workers in the health services. Rather it sets out to describe what one particular development worker in one particular health authority was able to accomplish. By outlining some of the tasks undertaken, the obstacles overcome, and some of the wider issues involved, it is hoped that Haringey's experiences will prove useful to other health authorities seeking to meet, in the words of the health minister, 'the management challenge of ethnic minority health'.

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