
Black and Minority Ethnic Health Service Provision in Liverpool Primary Care Trusts

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Executive Summary

Objectives:

To undertake a rapid appraisal of health services for minority ethnic groups within primary health care in Liverpool and to devise recommendations for the delivery of these services within the primary care trusts (PCTs) due to come into existence in April 2002.

Methods:

1. A literature search was undertaken to identify models of effective primary health care for minority ethnic groups.
2. Local publications were reviewed to ascertain the health needs of minority ethnic groups in Liverpool.
3. Interviews were conducted with representatives of relevant services in Liverpool. Interview schedules were designed to ascertain the services provided, how they were monitored and evaluated, evaluation findings and any perceived gaps in service.
4. The findings were used to devise recommendations for the development of health care services for minority ethnic groups within primary care trusts in Liverpool.

Recommendations:

1. Central Liverpool PCT should be responsible for commissioning and providing health care services for minority ethnic communities in Liverpool.
2. Central Liverpool PCT should develop an Ethnic Health Strategy in consultation with community groups through an Ethnic Health Forum. An Ethnic Health Co-ordinator and support staff should be appointed to oversee its development and implementation.
3. Each PCT in Liverpool should develop an Equalities Programme, linked to a Communications Strategy and the Patient Advice Liaison Service (PALS)
4. All GP practice staff should be trained on racial equality, cultural awareness and how to use health link workers, interpreters and telephone interpreting services.
5. More female GPs and primary care staff with relevant language skills should be recruited to areas with a high proportion of patients from minority ethnic groups.
6. Interpreting services should be developed in partnership with Central Liverpool PCT and should receive additional funding in order to recruit more interpreters, especially those speaking languages for which there is a current shortage, to increase the quality and reliability of the service and to develop more responsive ways of working.
7. GP practices and pharmacies in areas with a significant minority ethnic population should have access to an effective telephone interpreting system.
8. Additional health link worker time should be made available; in particular, male and female Yemeni health link workers should be appointed.
9. The roles of the health link workers should be clarified and the health link workers be fully involved as professionals in primary health care team meetings.
10. Additional translated health information should be made available in primary care, including translated medicine labels at pharmacies.
11. Standard letters, such as recall for cervical cytology, should be produced in common community languages such as Somali. Information technology should be developed to allow the production and effective targeting of translated letters.
12. Additional funding should be made available to support GPs providing care to asylum seekers and refugees and the development of additional services for this population.
13. Ethnicity profiling should be extended to all practices in Central Liverpool PCT and systems developed to use and share this information to effectively target services.

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1. INTRODUCTION

This report was commissioned by the Black and Minority Ethnic Health Equalities Action Team of Liverpool Health Authority to inform the commissioning of services for people from minority ethnic communities within the context of the new primary care trusts (PCTs), due to come into existence from April 2002. The findings of this report will be fed into:

- Black and Minority Ethnic Health Equalities Action Team
- Liverpool's NHS Modernisation Action Teams or equivalents
- Health and Regeneration Social Group
- Primary Care Trust Working Groups
- Health Improvement Programme 2002/3
- Services and Financial Framework 2002/3
- Primary Care Group/ Trust Accountability Agreement 2002/3
- Primary Care Investment Plans and Service Delivery Agreements.

2. DEFINITIONS

The term 'ethnic group' refers to a combination of factors including skin colour and physical features, family origin, language and religion. It is mainly a social construction and its significance is determined to a large extent by society¹. There is no universal agreement on terms; minority ethnic groups are also sometimes referred to as 'racial minorities' or 'visible minorities'.

3. OBJECTIVES

- To ascertain the level of and need for specific resources for people from minority ethnic groups within primary health care services in Liverpool:
- To identify models of known good practice to meet those needs.
- To identify the resources employed within Liverpool to meet those needs.
- To identify any gaps or short falls in provision.
- To assess how the current resources are evaluated.
- To devise recommendations for the commissioning and development of services within the context of primary care trusts.

4. METHODS

- A literature search was undertaken to identify effective models of primary health care provision for people from minority ethnic groups. Literature was identified through Medline, the World Wide Web, and local contacts.
- Local publications and reports were reviewed to ascertain needs for specific resources for people from minority ethnic groups using primary health care services in Liverpool.
- Interviews were conducted with selected staff of current health-related services for people from minority ethnic groups. Interview schedules were designed to ascertain:
 - The services that were being provided
 - How those services were monitored and evaluated
 - The findings of any evaluations
 - Any perceived gaps in service, services that could be improved or the identification of barriers to providing an effective service.

Where appropriate, these findings were supplemented by evidence from written reports.

Staff interviewed included representatives of:

- *Statutory agencies:*
 - Asylum Seekers Support Service (Liverpool City Council)
 - Health Link Worker Service (North Mersey Community NHS Trust)
 - Liverpool Central West Primary Care Group
 - Liverpool Central and Southern Community Health Council
 - Liverpool Translation and Interpreting Service
 - Liverpool Health Promotion Service
 - North Mersey Community Trust
 - North Mersey Community (NHS) Trust Asylum Seekers Support Team
 - Royal Liverpool and Broadgreen University NHS Trust
- *Voluntary agencies:*
 - Friends Information Centre
 - Irish Community Care
 - Liverpool Voluntary Society for the Blind
 - Project 8

5. BACKGROUND

This section describes the context of this review in regard to recent government publications, primary care and community health services in Liverpool and the demographics of minority ethnic populations in Liverpool.

5.1 Government publications

There is much current interest in reducing health inequalities between minority ethnic groups and the general population, in promoting equal opportunities and in developing health services more responsive to the needs of individuals and groups. Summaries of some of the major publications in these areas are presented below:

5.1.1 The NHS Plan

The NHS Plan², published July 2000, sets down five areas for NHS development: partnership, performance, professions and the wider NHS workforce, patient care and prevention.

It states that services should be responsive to the needs of patients, including minority ethnic groups, should challenge discrimination and should improve accessibility to all. A free, national interpreting service, available through NHS Direct, is planned for 2003. Discrimination and harassment of ethnic minority staff should be tackled and diversity within the NHS workforce improved. National targets will be set for the reduction of inequalities in health, including between minority ethnic groups and the general population.

By 2004, the majority of GPs should be paid through the Personal Medical Services (PMS) contract, on the basis of meeting quality standards and the needs of the local population. Along with other initiatives, including the development of primary care trusts, the new contracts should be used to improve the quality and accessibility of primary care in deprived areas, for example, by developing new services for minority ethnic communities or attracting doctors and nurses to work in deprived areas. Primary care trusts will be expected to undertake surveys of patient views and take those views into account to improve services. Patients should be provided with more information on looking after their own health, health services in the area and the treatment and care planned for them, including receiving copies of their referral letters.

The use of information and communication technologies should be widened and improved until all patient records are stored electronically and shared between primary and community services. GPs should have access to the NHS net and patients should be able to access their GP surgery for advice through telephone or e-mail services. NHS Direct will be extended to provide a route through which patients can access health services.

5.1.2 The Macpherson Report

The Macpherson Report³, published in 1999, defined institutional racism as:

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

Macpherson's recommendations for overcoming these issues included staff training in racial and multi-cultural awareness.

5.1.3 The Race Relations (Amendment) Act 2000

The Race Relations Amendment Act⁴, which came into effect in April 2001, gives public bodies, including the NHS, the general duty to pay due regard to the need to eliminate discrimination and promote equality of opportunity and good race relations when carrying out their functions. They are expected to monitor their staff by ethnicity, assess the impact on racial equality of proposed policies and to consult on them, and to monitor the impact of existing policies and practice on racial equality. Under the act 'discrimination' includes indirect discrimination, for example, distributing information only in English where a substantial proportion of the population is not able to read English, or omitting to provide services to certain minority ethnic groups.

To guide organisations in complying with the Act, the Commission for Racial Equality (CRE) has produced codes of practice for relevant organisations, including primary health care services. Guidance includes the need to translate information into the various languages used in the area, to provide interpreting services whenever necessary and to use the most appropriate channels of communication. Purchasers and providers should consult specifically with their local minority ethnic communities to ensure that their views and participation in the planning process are secured. The arrangements should take into consideration the different languages spoken, the form of the consultation and venue. Services should be assessed and evaluated jointly with local ethnic minority communities.

Ethnic monitoring of patients and regular reviews of policies and procedures should be undertaken. The main areas for monitoring are access, adequacy and quality. Any unmet needs, such as screening for specific illnesses or interpreting and translation services, should be identified and action taken to meet them.

Health authorities and PCTs should adopt race equality policies and all staff should receive training and guidance on the policies. Training is vital for the effective implementation of non-discriminatory practices and procedures. It should include examples of racial discrimination that are relevant to the particular service provided, how to recognise and avoid racially discriminatory treatment and awareness of cultural differences and their effects on health patterns and patients' needs. Actions should be taken to tackle racial harassment of patients and staff by patients and staff.

5.2 Primary and community health care services in Liverpool

Primary health care services in Liverpool are currently delivered by five level two primary care groups (PCGs) and one community trust, North Mersey Community NHS Trust (NMCT), which is responsible for two GP practices. Community health services are run by NMCT, which is divided into several localities for administrative purposes. The PCGs are currently sub-committees of Liverpool Health Authority, taking devolved responsibility for healthcare planning, provision and development and commission 60% of the total service budget. Figure 1 shows the positions of the five PCGs in Liverpool.

By April 2002, the five PCGs and the community health services of NMCT will be dissolved and replaced by three level four primary care trusts, providing integrated primary, community and intermediate health care services and commissioning other services for the local population. Figure 2 shows the configuration of these proposed trusts. Staff will be transferred from the PCGs and NMCT so as to retain their previous pay and working conditions. The primary care trusts are legally established free-standing bodies, able to own property and employ staff. They will be accountable to Liverpool Health Authority and later to the North West Strategic Health Authority through performance management.



Figure 1: Configuration of the five primary care groups in Liverpool

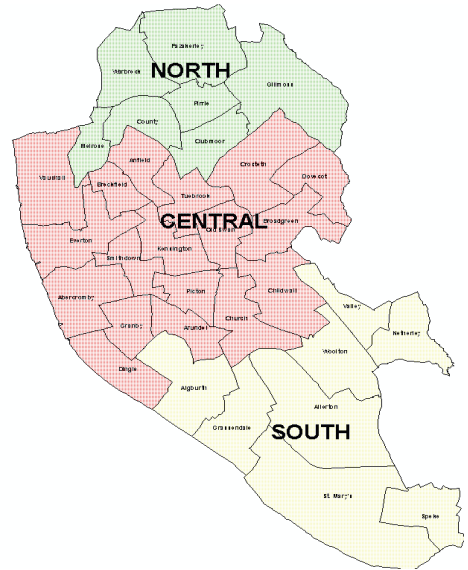


Figure 2: Configuration of the proposed primary care trusts in Liverpool

The integration of primary care and community health care services should provide a framework to more effectively address local health issues and a platform for closer working with Liverpool City Council, particularly Social Services, and the voluntary sector⁵.

5.3 Minority ethnic communities in Liverpool

In order to effectively plan services, demographic profiling information regarding the minority ethnic communities living in the area is needed. Most of the information contained in this section is taken from an EOLAS report⁶, commissioned by Liverpool Health Authority in 1995 to assess the health needs of minority ethnic communities living in Liverpool at the time. This information is supplemented and updated by reference to later reports where they are available.

According to the 1991 census figures, 3.5% of the population of Liverpool are of a minority ethnic group. The actual proportion was estimated to be higher, due to disproportionate under-counting of people from ethnic minorities, and is likely to be even higher now, following the recent migration of asylum seekers and refugees into the area. In addition, in 1991, 1.3% of the recorded population were from Ireland. Most ethnic minority communities are concentrated in the central wards of Liverpool, particularly Granby (28%), Abercromby (28%) and Arundel (14%). These wards are also amongst those that have the greatest concentration of socio-economic deprivation and poor health in Liverpool.

Over half of Liverpool residents from minority ethnic groups, including the majority of asylum seekers, live within the area served by Liverpool Central West PCG and the Central Locality of NMCT. Mersey Live PCG also serves a significant population of asylum seekers. The majority (80%) of Liverpool residents from ethnic minorities live within the area to be served by the proposed Central Liverpool PCT, including almost all of the asylum seekers currently dispersed to Liverpool.

Although the proportion of people in Liverpool who are of a minority ethnic group is not as high as in many other cities, there are a number of diverse communities with different cultural, communication and health care needs. Liverpool's largest minority ethnic communities are described below.

5.3.1 The Somali community

In 1995 it was estimated that there were over 2,500 Somali people living in Liverpool⁷, almost exclusively within the wards of Granby and Abercromby. There has been significant migration since that time as people fled from the civil war in Somalia: Somali health link workers now estimate the population to be around 5,000, a local Somali doctor estimates there to be around 4,000. Before 1988, there was a smaller Somali community of mainly seamen; these are now an elderly population who had not intended to stay. Most Somalis are Muslim and adhere to customs of segregation of the sexes. The population is predominantly young, with males outnumbering females. Seventy-two percent of Somali adults are unemployed, and the majority of households have one or more members receiving income support⁸. Over one third of households have adult members with language difficulties. Many Somalis, particularly older Somalis, do not read Somali, which did not become a written language until 1972.

5.3.2 The South Asian communities

The 1991 census counted 3,050 South Asian people in Liverpool. However, there were probably actually over 5,000⁹. Within the Asian communities, there are many distinct groups, originating from India, Pakistan and Bangladesh and following the Hindu, Muslim and Sikh faiths. Languages spoken include Urdu, Hindi, Bengali, Gujerati and Punjabi.

South Asians are widely dispersed throughout Liverpool. They are a relatively young population, particularly the Bangladeshis.

5.3.3 The Black communities

The 1991 census counted the size of the Black communities as follows:

- Black Caribbean 1,518
- Black African 2,469
- Black Other 3,275

The majority of Black Caribbeans are from Jamaica, Barbados, Trinidad or Tobago. Some settled after the Second World War, others during the 1950s and 1960s in response to labour shortages in Britain. The majority of Black Africans in Liverpool, not including the Somalis, are from West Africa. Many came over to Britain as seamen and now form an ageing population. The category of Black Other includes Black children born in Britain, many of who have a White parent.

The Black populations in Liverpool are concentrated in the Granby and Abercromby areas. They have few language problems, but experience discrimination and disadvantage, including an unemployment rate over twice that for the city as a whole.

5.3.4 The Chinese community

The Liverpool Chinese population was counted at the 1991 census as 3,314. The community is dispersed throughout the city, although 25% live within the Granby and Abercromby wards, with the greatest concentration found in the city centre area known as China Town, although this is a centre for Chinese culture and business more than a residential area. Most speak Cantonese, although some speak Hakka or Mandarin. They share a common written language and cultural identity. Seventy percent of first generation immigrants (one third of the population) cannot speak English. An estimated 90% of Chinese people employed in Liverpool are working in the restaurant and catering sector. There are also significant numbers of Chinese students studying in Liverpool.

5.3.5 The Yemeni community

The size of the Yemeni population was estimated at around 1,000 in 1995. The great majority of Yemenis live within the Granby, Abercromby and Dingle areas, although Yemeni shop keepers are scattered throughout the city. Most are Muslim and speak Arabic. Many have language problems; only 17% of women and 39% of men are literate in English. It is a young population, with over 37% under the age of 15 years.

The majority of Yemenis are self-employed, most as shop keepers in family businesses employing the husband and wife. Many live above their shops, where overcrowding and poor repair is common.

5.3.6 The Irish community

The Irish born population in Liverpool is estimated at 5,813. It is an ageing population, with 38% of males and 45% of females over the age of 60. Almost a third live in single pensioner households. There are also a number of Irish students attending local universities. Liverpool has a small permanent site for Irish travellers and is a short-term stopping place for larger groups of travellers at particular times of the year. Liverpool is also a 'stopping-off' place for young Irish people leaving home and seeking employment.

5.3.7 Asylum seekers and refugees

It is estimated by Liverpool City Council that there are currently 2,500-3,500 people living in Liverpool as temporary visitors waiting for the Home Office to examine their case for asylum. Almost all have arrived within the past two years, as part of the dispersal programme resulting from the 1999 Immigration and Asylum Act. Most are young men and very few speak English. They come from a range of locations but particularly from Iran, Iraq, Somalia, Sri Lanka, Afghanistan and Africa. Collectively, asylum seekers in Liverpool speak at least 50 different languages and dialects. Most live in conditions of poverty, as they are not allowed to work for their first six months in Britain, and are supported only to 70% of the current level of income support. Asylum seekers also tend to be in poor health⁹. Liverpool is not currently accepting more asylum seekers, as it is considered not to have the capacity. There are no statistics available yet as to where asylum seekers tend to settle after being given refugee status or leave to remain, but it is likely that a proportion will choose to stay in Liverpool.

6. REVIEW

This section presents a review of national and local literature describing the specific health needs of people from minority ethnic communities and models of known good practice in meeting those needs.

6.1 Health needs of people from minority ethnic groups

6.1.1 *Experience of illness*

Most minority ethnic groups in Britain have a higher burden of illness than the indigenous population, for example, the prevalence of long-term limiting illness is higher in all minority ethnic groups (except Chinese) than in the general population^{10,11}. Much of this difference is due to the higher levels of poverty and lower socio-economic status of minority ethnic groups as compared with the general population, but when socio-economic status is taken into account, levels of ill-health are still higher¹¹. Experience of racism, social isolation, difficulties in resettlement and lack of awareness of health services may contribute to this. For example, in a recent study, 4% of Black Caribbeans, 5% of Indians and 8% of Pakistanis said that they had been the victims of a racially motivated incident in the past year¹².

Certain health problems affect some minority ethnic groups to a greater extent than the White British population. Some of these problems are summarised below:

- *Diabetes*

Diabetes is five times more prevalent amongst South Asian men than White British men; 20% of South Asian men develop diabetes by the age of 55¹³. Diabetes is at least twice as prevalent in Black African and Black Caribbean populations than in the White British population, and the rates of complications, including mortality, are also higher^{10,14}. It is thought that genetic factors play a large role in the difference in prevalence, with factors such as awareness of the disease and access to services playing a role in the higher rate of complications. Local studies have indicated that prevalence of diabetes may also be raised amongst the Yemeni population⁶.

- *Ischaemic heart disease*

Ischaemic heart disease is over 30% more prevalent and early deaths from heart disease 2-3 times more prevalent in South Asian men as compared with the general male population¹⁰. It is thought that the increased prevalence of heart disease is linked to the increased prevalence of diabetes.

- *High blood pressure and cerebro-vascular accidents*

High blood pressure and cerebro-vascular accidents, including strokes, are more common amongst Black African and Black Caribbean populations than the population in general. In African-Caribbean men, deaths related to hypertension are four times more common than in the general population, and in women death rates from hypertension are seven times higher. This is due to a combination of hypertension being more common and the effects being more severe. Mortality from stroke is twice as high amongst the African Caribbean population in Britain as for the general population¹³.

- *Inherited blood disorders*

Inherited blood disorders occur in populations originating from areas where malaria is endemic¹³. Around one in 200 Black African and Black Caribbean people have sickle cell

anaemia and one in 12 have sickle cell trait (carriers). Black African and Black Caribbean people and those from the Middle East, Mediterranean, South Asia and China are affected by thalassaemias and glucose-6-phosphate dehydrogenase (G6PD) deficiency.

- *Infectious Diseases*

Certain infectious diseases, including tuberculosis, HIV/AIDS and hepatitis are more common amongst recent immigrants from areas where they are endemic¹⁵, and in more settled populations with family origins in these areas. Recent immigrants may also suffer with chronic malaria, parasites, sexually transmitted diseases and various tropical infections¹⁶.

- *Female circumcision or genital mutilation*

Female genital mutilation is practised in various forms in certain African and Arab countries, including Somalia. Women affected by this practice may experience problems with sexual intercourse and childbirth. The practise has been illegal in Britain since 1983.

- *Mental health problems*

Mental health problems are especially prevalent in refugee populations, including asylum seekers¹⁶ and many members of the Somali¹⁷ and Yemeni⁶ communities. Problems encountered include post-traumatic stress disorder and other symptoms of stress and distress, including addictions, depression¹⁸, behavioural problems in children¹⁶ and general difficulties in resettling²⁰. One study found that two thirds of refugees who had been in Britain for between two and ten years suffered to some extent with anxiety or depression¹². Causes of distress include war trauma, family death and separation, language difficulties, social isolation, racial harassment, delays and uncertainty about immigration status, unemployment, poor housing and other difficulties in adapting to a new country. Often, the patient does not require a specialist mental health intervention but can be helped by the opportunity to talk about their experiences²⁰ and through social initiatives to increase independence and time spent on creative activity and to reduce isolation¹⁶.

Depression is more common within the South Asian and Irish communities than in the population as a whole, and alcohol related disorders are nine times more common amongst the Irish population than the general population²¹. Black British people are ten times more likely to be diagnosed with schizophrenia or to be compulsorily admitted to mental hospital than the general population, possibly due to cultural factors associated with diagnosis²².

- *Injuries*

Injuries caused by war (including landmines), torture, rape and arduous journeys affect some refugees and asylum seekers²⁰. Refugee women may also be particularly vulnerable to domestic violence²³.

- *Dental problems*

Dental health is poorer amongst members of minority ethnic groups, who are also less likely than the general population to visit a dentist regularly^{4,1}.

6.1.2 Barriers to accessing health services

A major problem faced by members of ethnic minorities is access to health services. Some of the barriers to access are summarised below.

- *Language and cultural barriers*

Differences in language and culture between health service providers and users create barriers to effective communication, restricting the uptake of services by people from minority ethnic groups, reducing the effectiveness of treatment they receive, decreasing their satisfaction with many aspects of care and frustrating those who try to provide services²⁴. Language is the most obvious and fundamental barrier to communication, most relevant to first generation immigrants from non-English speaking countries, including many members of the South Asian, Somali, Yemeni, Chinese and asylum seeking communities. The problems are not simply of interpreting; patients may have problems in communicating symptoms because of the difficulties in interpreting a different set of health beliefs, for example the Chinese way of describing symptoms in terms of hot and cold within the body²⁵. In one study, Asian patients with access to an Asian doctor speaking their own language still perceived a language barrier, due to medical jargon²⁵.

Access to health information, for example on immunisation, screening or healthy eating is restricted in communities who are not able to understand materials produced only in English. In addition, some communities, for example, the Somali community, have a high proportion of individuals who are not literate in their first language.

Cultural barriers may be more difficult to tackle than language barriers²⁵. For example, there may be religious and cultural restrictions on discussing personal issues, especially with a member of the opposite sex, or on undressing in front of a member of the opposite sex. These factors apply particularly to Muslim men and women. Some ethnic minority patients may experience or perceive racism or stereotyping by staff, or find that doctors are unsympathetic to their experience, for example as refugees¹⁸. Some communities tend to rely on traditional remedies rather than conventional medicine, and may have very different ways of seeing and describing health, for example, South Asian patients often describe mental health problems in terms of physical symptoms^{18,21}.

Problems with access apply equally to social care services, for example, nursing homes, residential homes for the elderly, home helps, services for disabled people and support for carers. Elderly people in particular may experience problems with language and culture, as they tend to be first generation immigrants, and language problems may become more acute in people with dementias such as Alzheimer's disease.

- *Lack of awareness of the services available or how the NHS works*

Lack of awareness of services can affect all disadvantaged groups in society, but is particularly relevant to people who have recently arrived in the country and to people who do not speak or read English. Recent arrivals, for example, may not have experience of appointment systems, primary care led services, screening programmes or child health surveillance. Asylum seekers may be unaware that the GP offers a confidential service that is separate from the Home Office¹⁸.

- *Practical barriers*

Practical barriers to accessing services may be experienced by any member of society, but are particularly relevant to certain minority ethnic groups. For example, many Chinese, Bangladeshi and Yemeni people work long hours in take-aways, restaurants and shops and may not be able to spare time during working hours to visit a doctor or dentist. People may not wish to walk to a health centre for fear of racism or may not wish to use public transport due to

language problems, fear of racism or lack of money (particularly relevant to asylum seekers, who receive very little cash benefit). People from mobile populations, including asylum seekers and travellers, may sometimes be offered only temporary registration with a GP, in which case records may not be available and patients may not receive services such as health checks, screening and immunisations.

6.2 Good practice in health care for minority ethnic groups

The provision of health services for people from minority ethnic groups should be based on needs assessment information obtained from demographic data, ethnic monitoring, specific research where appropriate and consultation with local minority ethnic communities. Services should be integrated within an overall strategy for minority ethnic health and should be regularly monitored, evaluated and reviewed. In areas with a significant ethnic minority population, an ethnic health co-ordinator and ethnic health advisory committee should be appointed²⁶. Funding for ethnic minority services should, where possible, be mainstream, to avoid marginalising the clients or services²⁷.

In a review of published national and international literature, the following services were identified as important in improving access to health services for minority ethnic groups.

6.2.1 Interpreting

The availability of interpreting is the most important factor governing access to health services for people who have difficulty communicating in English¹. As good practice, professional, trained interpreters should be made available wherever they are needed. Friends or family members, particularly children, should not be routinely used as interpreters, as the interpreting may be inaccurate, patients may feel inhibited, and distress may be caused to both patient and interpreter^{25,27}. Where volunteer bilingual staff members are called upon to interpret, they may not have the necessary skills and may feel obliged to help at the expense of their own work and without reward²⁷. Interpreters should ideally be of the same sex as the patient, especially if the patient is Muslim, and should be 'mature'. Some communities are divided due to civil war in their homeland, and care should be taken to ensure that the interpreter is acceptable to the patient. Interpreters in some situations may be more effective where they have some relevant health or mental health knowledge²⁸.

Interpreting can be provided either with the interpreter physically present, translating for the patient and clinician after they speak, from a remote site through headsets worn by the clinician and patient, translating simultaneously, or through a telephone system, translating after the clinician and patient speak. Studies suggest that using remote, simultaneous interpreting is the most accurate method and preferred by patients and clinicians²⁹. Telephone interpreting systems such as National Language Line, where interpreting is remote but not simultaneous, have been shown to be of limited use, especially where a consultation is complicated or stressful³⁰, however, to ensure patient safety, some language provision is needed for those who present acutely³¹. Where an interpreter is present and they share a culture with the patient, they have the advantage of being able to assess gestures, body language and cultural differences in how things are described.

In areas with a significant minority ethnic population, health services should collect data on patients' country of birth, preferred language and whether an interpreter is needed. Records of patients who require an interpreter should be marked for easy identification²⁶. There should be a centralised interpreter booking system and a three-way telephone interpreting system available at the reception²⁶. Outreach and community workers should have mobile telephones with access to a telephone interpreting service²⁶. The centre should have multi-lingual notices, explaining the use of interpreters, displayed in the waiting and reception areas²⁶. For monitoring

purposes, data should be collected on the use of interpreting services²⁶. Health care staff should receive training and guidelines on how to use an interpreter^{25,27}.

Where possible, interpreting should be available outside normal working hours¹. People with difficulties communicating in English may be forced to use hospital Accident and Emergency services rather than more appropriate primary care services if they are unable to communicate with the out-of-hours service²⁵. Where continuity of care is essential, especially for counselling interventions, the same interpreter should be used at each appointment²⁶.

6.2.2 Health link workers

Health link workers form a link between the health care services and the community they serve to improve access and communication. The concept of the health link worker was born in Britain in 1979, when staff working on the 'Stop Rickets Campaign' recommended that liaison workers be employed to facilitate communication between healthcare professionals and the South Asian communities²⁴. The first link workers to be employed within the NHS worked on the 'Asian Mother and Baby Campaign', funded in certain areas for two years through a DHSS grant. Since then, some health link worker schemes developed from that project and others were set up independently by other health authorities²⁴. Link workers are employed by a variety of organisations and their roles are varied, usually including interpreting and mediating between patient and professional to explain patient concerns and professional advice in terms that are more consistent with each's values, beliefs, knowledge and assumptions³². They can act as advocates for the communities and advisors to the health services, increasing the awareness of ethnic health issues amongst health staff and helping to alter the delivery of health care to suit minority ethnic communities³³. They are also useful in the delivery of health promotion and prevention activities.

Within primary health care, health link workers can be an especially useful resource for new patient health checks, screening, immunisation and advice, chronic disease management, women's health, mental health and health promotion. In a study of the use of health link workers in a maternity service, women with link worker support had fewer problems before, during and after birth than women without³⁴. The link worker intervention was cost-effective, as it reduced the need for further medical interventions.

Some authors advocate separating the role of health link workers from that of interpreters, provided that there are enough interpreters available, to give link workers the time to play a wider role in promoting health and acting as a link between communities and health service providers and commissioners¹. However, it is also recognised that interpreters who simply act as a neutral third party and concentrate on exact word-for-word interpreting are less effective at overcoming cultural barriers to communication²⁴. Patients who are less confident and who do not understand the structure of services may also benefit more from the input of a health link worker than an interpreter²⁴.

Link workers should have clear job descriptions and both the link workers and other staff should have clear guidelines on their role³³. To ensure their status as a professional within the health care team they should have an adequate salary, opportunities for advancement and be involved in agency decisions³³. They can work more effectively within their remit if there are culturally competent services available to refer to, and if link workers or bilingual support workers are available within other human services, such as housing, welfare benefits and social care³³. Where they are involved in prevention and health promotion activities, better results are obtained when task is clearly defined³³. Health link workers need adequate supervision, support and training. Supervisors should promote links with other agencies and attend important community functions.

6.2.3 Bilingual staff

The need for interpreters and link workers is reduced where staff members are available who speak the language of minority ethnic communities living in the area. If possible, a number of bilingual staff should be employed²⁶. A strategy for recruitment of bilingual staff may include providing grant-aided training for health professionals whose qualification is not recognised in the UK²⁵.

6.2.4 Translation

Translated information should be available regarding the health centre²⁶, the health services generally¹⁸, screening and immunisation programmes and specific common illnesses, their treatment and prevention¹. Studies have shown that where the purpose of a screening test is adequately explained, women from ethnic minority communities are happy to participate. Translating information is not simple, as health beliefs and other cultural factors need to be taken into account, and great care is needed¹. Translated leaflets could be displayed in areas other than health centres, for example, local Chinese supermarkets²⁵, mosques and temples. Local radio and audio cassettes can also be used to provide health information¹, and are especially useful for people who cannot read their own language due to literacy problems or visual impairment.

Pharmacists should use and display information and provide instructions on how to take prescribed medicines in the appropriate community languages.

6.2.5 Culturally appropriate services

All healthcare and reception staff should receive cultural awareness training, covering religious and dietary needs, naming systems, social customs and, where appropriate, refugee specific issues, including the need to register asylum seekers as permanent patients²⁵. In the case of GPs, this training should include the health beliefs and health problems specific to different communities. All health services should have anti-discriminatory policies and practices³⁵.

Many people prefer to see same-sex GPs and health care staff³⁶. This is particularly important for Muslim women, who may feel uncomfortable and may even feel unable to attend some services where males are present³³. It is important that there are adequate numbers of female GPs and other female health care staff in areas with a significant minority ethnic population²⁵.

Service providers should consult local community groups on the planning and provision of appropriate health services, for example through an ethnic health forum¹. They should recognise barriers to access, including, in the case of social or hospital care, issues such as religious, dietary and washing needs³⁷. People from minority ethnic groups often feel more comfortable accessing services where some of the staff is from their community. Attempts should be made therefore to recruit staff from diverse ethnic backgrounds, and health services should undertake ethnicity monitoring of staff. People with healthcare qualifications not recognised in the UK could be assisted to qualify using grant aided training, or could be utilised in health promotion, advocacy or advisory roles²⁵.

6.2.6 Specific projects and services

Although health care for people from minority ethnic groups should be provided as far as possible within mainstream services, specific services are appropriate in some circumstances³³. Some examples of specific services that may be useful where a need is indicated are listed below.

- *Mental health services*, particularly those aimed at refugees and the victims of rape, torture or multiple bereavement. Post-traumatic stress syndrome resulting from these experiences

can respond well to early treatment. However, it is difficult to explain problems of a psychological nature in a foreign language³⁸, and the western counselling/ psychotherapy approach may not be culturally appropriate; some refugees need a more directive approach¹⁸. A non-medical atmosphere of services may be more acceptable to people from minority ethnic groups³⁴. Two specialist services are available in London: Traumatic Stress Clinic at Middlesex Hospital and the Medical Foundation for the Victims of Torture. Local services set up in other areas include a refugee support centre providing counselling and psychotherapy in a range of languages and a Somali mental health project employing Somali psychiatrists and health workers³⁴. These services combined language skills, medical knowledge and knowledge of the refugee experience, often employing staff mainly from the communities served.

- *Women's health services*, combining an all-female environment, language support or bilingual health workers and awareness raising/ health promotion may be appropriate in areas with a significant population of Muslim women.
- *Inherited blood disorders*, relatively common in some minority ethnic groups, are very rare in the White British population, and mainstream health services may lack the knowledge and expertise to screen for, treat and advise on these problems. To ensure that clients receive the language support, culturally appropriate service and medical expertise that they need, a special service may be required, possibly including genetic counselling in other languages¹³.
- *Diabetes and heart disease* are more common amongst South Asian populations than the general population, and the correct treatment/ advice for a South Asian person may be different from that for a White British person, due to genetic and cultural factors. In areas with a large South Asian population, special clinics, with bilingual staff or interpreters, may be useful¹³.
- *Health promotion* projects may be required to address issues specific to or more prevalent amongst minority ethnic communities.

7. WORK UNDERTAKEN IN LIVERPOOL

This section describes work undertaken in Liverpool to meet the specific health needs of people from minority ethnic communities. Information was obtained from local reports and publications and through interviews with key staff. Boxed sections describe issues identified, either by respondents interviewed or by comparison of service provision with the models of good practice identified in section 6.2.

7.1 Needs assessment, planning and consultation

7.1.1. Research projects

A number of needs assessment exercises, looking at the health of people from minority ethnic groups, have been undertaken in the Liverpool and North West areas. Many of these have led to specific initiatives or changes in health care provision.

Examples include:

- A research project, undertaken over a one-year period from 1995 to 1996, to assess the provision of and access to heart disease prevention and treatment services for South Asian people in Liverpool. From this, a three-year health promotion project, the South Asian Heart Health Project, followed⁶.
- An assessment of the mental health needs of the Somali community, undertaken by EOLAS in 1995⁷. A need was identified for the provision of a counselling service with Somali speaking staff, although this recommendation was not implemented.
- A health needs assessment for the Yemeni community, undertaken in 1996 by students of the Health Education and Health Promotion course at Liverpool School of Tropical Medicine. A need was identified for a Yemeni support or link worker. This proposal was supported by Liverpool Health Authority/ Liverpool Central West PCG, although it has not yet been implemented.
- A mental health needs assessment for asylum seekers, currently being undertaken to provide information to the Adult Strategic Reference Group at Liverpool Health Authority.
- A research project, undertaken by Liverpool Hope University, to assess the needs of disadvantaged women, including those from ethnic minorities, in breast screening.
- A research project, undertaken by Irish Community Care, into the problems of homelessness, mental illness and substance use amongst Irish people in Liverpool.
- A health impact assessment of the asylum seekers' dispersal policy in Liverpool, commissioned jointly between Liverpool Health Authority, Liverpool City Council and NMCT and currently in progress.
- Demographic data is available regarding people from ethnic minority groups in Liverpool³⁵. However, this is based on the 1991 census, and hence is out of date and very broad in some of the categories, for example, Somali people are classified only as 'Black African' and Yemeni people only as 'Other'.

7.1.2 Ethnicity profiling

A pilot of ethnicity profiling in primary care was undertaken at Princes Park Health Centre³⁶. Data collected included country of origin, religion, spoken and written language preference, health problems and social factors that could affect health, such as housing. This data was used to identify population needs, for example, for recorded information in different languages, and individual needs, such as that for language support. The ethnicity profiling model is currently being rolled out into ten GP practices within Liverpool Central West PCG.

7.1.3 Community groups and forums

Various community groups and forums work within Liverpool to identify and meet the health needs of people from ethnic minorities. Examples include:

- The Friends Information Centre, funded through the Liverpool City Council Urban Programme, provides an information and campaigning service for the South Asian communities of Liverpool. They see their role within health as one of developing awareness and facilitating contacts. They have well-established links with the local Asian communities, Liverpool Health Authority, and Liverpool City Council through membership of various committees including the Family Practitioner Committee in the 1980s, the Community Relations Council in the 1960s and the Community Health Council up to the present day. The Friends Information Centre also organises two forums of relevance to health: the South Asian Health Network and the Quality of Life Committee.
- Toxteth Health and Community Care Forum works to provide health information and support to people living in the wards of Granby, Arundel, Abercromby and Smithdown, and includes minority ethnic groups as one of their main priorities. The forum responds to the expressed needs of the local population by highlighting issues to statutory authorities, providing assistance in the start up of self-help type groups and organising specific projects. They have also undertaken research, for example, on the link between asthma and air pollution in the area.
- Two multi-agency ethnic health steering groups, covering diabetes and women's health respectively, meet regularly to discuss needs and to plan projects and services. Group members include health care and health promotion providers, health link workers and representatives from minority ethnic community groups.
- Irish Community Care provides support services for the Irish community and works with statutory authorities to highlight the needs of the Irish community, including Irish travellers. They recently started a forum with representatives from Liverpool City Council, Merseyside Police, and a health visitor to discuss ways of meeting the needs of Irish travellers in Liverpool.
- Liverpool Health Authority lead a Black and Minority Ethnic Health Equalities Action Team and a Valuing Diversities Group.
- The Royal Liverpool University and Broadgreen NHS Hospitals Trust (RLUBH) has forum for staff whose first language is not English, as part of its equal opportunities practice.
- Liverpool Central and Southern Community Health Council formed a Race Health Strategy Group to draw up a race and health strategy for RLUBH.

7.1.4 Black and minority ethnic health action plan

Liverpool Health Authority published an action plan, developed in partnership with local NHS trusts and primary care groups, Liverpool City Council and representatives from the Black, Somali, African, Yemeni, South Asian, Chinese and Irish communities, for black and minority ethnic health for 2001-2002, to be reviewed annually³⁹. This sets out four strategic objectives, based on those of the NHS Plan:

- Prevention and inequalities
- Patient care (access and empowerment)
- Professions
- Partnership working

Priorities set out in the plan include patient profiling and ethnicity monitoring, communications for all (including the provision of adequate interpreting and translation services), culturally sensitive services, workforce planning and policies on racial harassment of NHS staff.

Issues identified

Need to integrate ethnic health services together more closely

It was suggested that there should be a more defined and integrated system of provision for ethnic minorities, utilising economies of scale to provide a more comprehensive service that is value for money. Examples included a central database of ethnic health work in the area and contacts speaking different languages and/or with expertise in different areas of relevance. Lack of funding for ethnic health and the short-term nature of much of the funding that is available was also identified as an issue.

Lack of support for people from English speaking minority ethnic groups

Some respondents expressed concern regarding the lack of support services for English speaking minority ethnic groups, including the first generation Africa-Caribbean and Irish communities. Needs identified included a low level of GP registration amongst elderly Irish people living in Liverpool, who often do not wish to 'bother the doctor'.

7.2 Interpreting Services

7.2.1 Liverpool Translation and Interpreting Service

Liverpool City Council has a service level agreement with Liverpool Health Authority to provide interpreters free of charge to general practitioners in the area. Liverpool Health Authority pays Liverpool City Council and administrative charge for each interpreting appointment in addition to an annual contribution towards the service's overheads. In 2000/01, this totalled £19,643.98 (£9,643.98 in administrative charges plus £10,000 contribution). Other primary care practitioners, such as dentists, opticians and pharmacists are not covered by this agreement, although dentists and opticians do sometimes use the service. The majority (82% during the 3-month period 01/04/01 to 23/06/01) of the service's interpreting work is within health services, including NMCT Royal Liverpool and Broadgreen University Hospitals NHS Trust, Royal Liverpool Children's Hospital NHS Trust and Liverpool Women's Hospital NHS Trust. Liverpool Health Authority was the biggest user of services. During the financial year 2000 to 2001, interpreters were requested to attend at 30 GP practices, and a further seven practices requested interpreters during the first 12 weeks of 2001/2002. Certain GP practices, principally those with a large asylum-seeker population, used interpreters on a large number of occasions; others used the service only once or twice.

Interpreters employed by the service are requested where possible to have a bilingual certificate and a diploma in public sector interpreting, for which they underwent training in commonly used health terms. The recent increase in the number of languages requested has meant that the service has been unable to insist on these qualifications. They are currently in the process of assessing all their interpreters using a proforma covering qualifications and experience (see appendix i). Most are registered nationally, and some are members of the Institute of Translation and Interpreting, the only independent professional association for interpreters in the UK. They work on a freelance basis, being paid for mileage and time at the job. Most are willing to work evenings.

Liverpool City Council currently has interpreters on its books speaking a total of 57 different languages. If a request is received for another language, they approach other sources, including the North West Translators Network and the University of Liverpool Language Learning Centre, which specialises in European languages. There were 35 different languages requested during the three month period 01/04/01 to 26/06/01, the mostly commonly requested languages

were Kurdish, Farsi, Czech, Arabic, Chinese, Albanian and Somali, for which there were each over 100 requests.

Interpreters are allocated through a booking system. GP practices send an order form to a dedicated fax machine, giving at least three days notice for non-urgent appointments. An interpreter may sometimes be booked at shorter notice or even straight away, but this is dependent on availability. Where there is a cultural reason, a same-sex interpreter is provided and all interpreters sent to Liverpool Women's Hospital are female. A female interpreter is requested in almost 20% of cases, a male interpreter in almost 5% of cases. The service provides guidelines and offers training on the effective use of interpreters, but the training is rarely taken up.

Records of all interpreters booked are entered into an electronic database for monitoring purposes. NMCT undertake evaluation of the interpreting service after each contact, from the health workers perspective (see appendix ii).

The service is currently undergoing a review of how it could provide a more comprehensive service. Ideas put forward include targeted telephone interpreting for functions such as booking appointments and identifying the problems for patients presenting acutely.

7.2.2 Health link workers

If a health link worker is involved with a patient in primary care, they interpret at the first visit to hospital out patients. In certain circumstances, including terminal illness and cases where a lot of people are involved, the link worker continues to interpret on subsequent visits. The health link workers are, however, not trained in interpreting.

7.2.3 Telephone interpreting systems

The community clinics and GP practices run by NMCT have access to National Language Line, a commercial telephone interpreting service. Language cards are held at the reception desks. New patients point to their language on the card and NMCT staff telephone National Language Line with a request for that language. National Language Line is expensive but has a very wide range of languages, is easy to access and always responds within ten minutes. It is paid for with a retainer and call charge.

7.2.4 Volunteer interpreters (Community Health Council)

The Community Health Council is able to access interpreters free of charge through community groups, to provide support to people who wish to make a complaint or enquire about health services in the area.

7.2.5 Policies and systems

The NMCT Asylum Seekers Support Team has set up a system with Liverpool Women's Hospital where asylum seekers notes are 'tagged' to allow them to plan for interpreters, help with completing forms, etc.

All NMCT sites have a copy of the trust's manual, 'Communications for All', containing a list of staff who are bilingual and willing to act as interpreters where needed, procedures for booking and using an interpreter and procedures for using National Language Line. Staff members are asked at their induction if they speak any foreign languages and if they would be willing to act as an interpreter. A similar volunteer bank has been piloted amongst the asylum seeker population registered at Princes Park Health Centre.

The NHS hospital trusts have policies on the use of interpreters and link workers that they include in their handbooks for GPs. The NMCT Asylum Seeker Support Team has produced an information pack, sent to all Liverpool GPs, containing information on the interpreting services currently available.

Issues identified

Capacity

Since asylum seekers began to arrive in Liverpool through the dispersal process in April 2000, the workload of Liverpool Translation and Interpreting Service has greatly increased, but the resources available to it have not increased. Trends show that the rate of requests from GPs for interpreters has more than doubled since 2000, with over half as many requests being made in the first 12 weeks of the financial year 2001/2002 as for the entire financial year 2000/2001. There is a particular shortage of interpreters in languages new to the area such as Kurdish and Albanian. Although progress was made in recruiting interpreters in languages new Liverpool, many now work mainly for the Home Office on immigration cases, work which pays better, and are unwilling to take on work in hospitals and clinics. There are many more applicants who have been awaiting assessment to become interpreters for some time, due to serious staff shortages within the service.

Cover outside office hours

Locum GP services are not able to use Liverpool Translation and Interpreting Service free of charge, and some interpreters are not willing to work evenings, so interpreting is often not available outside of normal office hours.

Provision in non-health settings

Interpreters have not been available at the Registrar's Office in Liverpool, meaning that people who cannot understand English have great difficulty in registering births; a legal requirement and necessary in order to claim certain benefits such as maternity benefit.

Service monitoring

Due to the massive increase in interpreter requests, Liverpool Translation and Interpreting Service found it impossible to respond to demand and provide up-to-date monitoring reports as required by the service levels agreement with Liverpool Health Authority. A new customised database was designed and piloted in 2000 and implemented in 2001. It is enabling the service to provide more accurate monitoring data and to identify trends.

Need to implement and utilise ethnicity profiling

There were concerns expressed that with the current lack of ethnicity profiling data, some patients with language difficulties were not being targeted to receive the help available.

Training and awareness

The NMCT Asylum Seeker Support Team reports receiving many telephone enquiries from GPs, asking how to access and use an interpreter. This has been especially apparent in practices that, before the arrival of the asylum seekers, had few non-English speaking patients. Practice staff members are often not able to use the language cards and telephone interpreting service effectively and there are occasional reports of reception staff being insensitive towards interpreters and their clients. These factors all suggest that training is needed. It is, however, difficult to arrange training on the use of interpreters in primary care because of the cost of replacing staff while they are away.

Burden on primary care

Consultations through an interpreter take at least twice as long as consultations with English speaking patients. This puts a strain on primary health care services already serving a deprived community with high levels of ill health. There is currently no method of making additional payments specifically to support GP practices to provide care for patients who need the input of an interpreter.

Efficient use of resources

The Liverpool Translation and Interpreting Service reports that some GP practices have been positively organised in the way that they have used interpreters, for example, one practice arranged for an interpreter to be present at the new patient health checks of 39 Albanian speakers. If all practices were encouraged to work in this way it could greatly increase the efficiency of resource use.

Lack of continuity between primary and secondary care

There are reports of patients who do not speak English being moved inappropriately between primary and secondary care; for example, of a woman attending Liverpool Women's Hospital as an emergency case being sent to her GP afterwards to explain what was wrong with her. This, and the move towards more shared care by primary and secondary care suggests that the two sectors need a joint strategy for communication with non-English speaking clients.

Potential availability of interpreters within the community

The Royal Liverpool and Broadgreen University Hospital NHS Trust report that a number of people have contacted them offering to act as volunteer interpreters, but they have not been utilised because they have not been assessed or accredited. This suggests a significant untapped resource of local people who would be able to act as interpreters if the right assessment and/ or training was provided. Similarly, there are known to be a number of asylum seekers living in Liverpool who are able to speak English in addition to their own language, some of whom were medical practitioners in their own country. There may be additional problems in using this group, concerning payment and confidentiality.

Problems with the system of link workers interpreting on a first hospital appointment

The system where a link worker interprets on the first hospital appointment only and an interpreter is booked for any subsequent appointments does not always work effectively. Health link workers have come under pressure from trusts and patients to attend further appointments. Some of this pressure has arisen from the fact that the trusts have to pay for the use of interpreters. Health link workers report that the system of interpreting only once breaks the trust with the community; that is difficult to explain to the patient and community why they cannot interpret on the second appointment. They report that interpreters often do not turn up for appointments and that patients are often not informed of whether an interpreter will be coming or not. Thus patients may request a link worker because they do not know that an interpreter has been booked, and both attend, or, if an interpreter does not arrive, they may get no interpreting at all.

Communications

There are reports of poor communications systems between primary care, secondary care, interpreters, health link workers and patients. Liverpool Translation and Interpreting Service report, for example, hospitals and clinics faxing requests without stating the patient's language or gender.

7.3 Health link workers

7.3.1 Service provision

NMCT employs four full-time and three part-time health link workers to serve non-English speaking communities in Liverpool. Although they are NMCT employees, they work where they are needed, with no differential between GP and community services. The full-time health link workers include:

- Two Chinese health link workers, both female. They are based at Abercromby Health Centre and also attend St James Health Centre in China Town every morning, and work at other locations throughout the city.
- Two Somali health link workers, one male and one female. The male worker is based at Abercromby Health Centre and the female worker is based at Princes Park Health Centre. Both speak Somali and Arabic.

The three part-time link workers are female and were initially employed to serve only the Muslim and Multi-cultural Women's Health Clinic at Abercromby Health Centre. Their roles are mainly with mothers and babies, including accompanying health visitors and doctors on home visits and explaining child health problems and abnormalities. They attend the Link Clinic at Liverpool Women's Hospital and also attend immunisation clinics when requested by the health visitor. They include:

- A Yemeni link worker who speaks Arabic. She works for one session per week at a GP practice with a high proportion of Yemeni patients.
- A Bangladeshi link worker who speaks Bengali, Urdu and Hindi. She works for one session per week at a GP practice with a high proportion of Bangladeshi patients.
- An Indian link worker, who speaks Punjabi, Urdu and Hindi.

Central West Primary Care Group is currently exploring the appointment of two part-time

Arabic speaking health link workers (one male, one female). Their appointment has been delayed by unresolved discussions concerning their role, training and management.

Both the full-time and part-time health link workers have undertaken awareness raising work around the services provided by Glaxo Neurological Centre, the Alder Centre (a bereavement counselling service for people who lose their children) and Liverpool Voluntary Society for the Blind, and health promotion work around diabetes and women's issues. The part-time link workers have attended meetings on HIV and mental health so that they can explain about HIV to patients and provide information on mental health support available, especially for women who lose their babies. They have also attended a listening course organised by 'Building Bridges', so that they can help to identify dysfunctional families for possible referral.

The current agreed roles of the health link workers, set out in their job descriptions, are as follows:

- Interpreting for people on their first visit to the GP surgery, health centre or hospital.
- Facilitating the communities' access to health services.
- Advising health care professionals on matters of culture.
- Undertaking health promotion under the guidance of Liverpool Health Promotion Service.

The health link workers have their own telephone line and answering machine at Abercromby Health Centre, where they answer queries direct from patients and health professionals. Sometimes they interpret for the GPs and dentists at the health centre.

The Chinese and Somali health link workers, in response to the priorities of the communities, have, in the past, concentrated mainly on interpreting, although they were not trained for this role. In 1997, notices were circulated to the effect that the health link workers would interpret only on the first visit, after which the health services would need to book an interpreter.

The health link workers are members of the Toxteth Health and Community Care Forum, and have been involved in health promotion and social support projects organised through the forum. For example, the Somali health link workers are currently in meetings with the forum to discuss concerns over the high number of Somalis dying through suicide. The health link workers also represent their communities on the Multi-Cultural Diabetes Steering Group and the Female Genital Mutilation Steering Group (Somali link workers only). They have been involved in various other health promotion activities such as work at WHISC (Women's Health Information and Support Centre) addressing women's health issues and smoking cessation work with FAG ENDS.

The Somali health link workers visit young Somalis at the mental health units of Broadoak and Windsor House to explain what is happening to them and explain things to the family. The health link workers sometimes work with Social Services at the interface of health and social care, for example, they accompany social workers on visits to assess people with disabilities. The Somali health link workers support asylum seekers from Somalia to provide help with GP registration and advise on issues such as buying food or problems with housing.

Issues identified

Access

Some concerns were expressed regarding access to health link workers, who spend most of their time at two health centres, Abercromby and Princes Park, with the result that patients registered at other GP practices may not always receive the service they need. Some patients do not receive health link worker input because a lack of ethnicity profiling data means that their needs are not identified. Link workers are not able to fully develop their links with community centres, because the community does not have access to generic link workers to help the community with issues such as completing forms. Link workers currently report taking on this kind of role within their own time. However, the link workers report that access is improving due to their promotion of the service locally.

Remit

The health link workers are under pressure to interpret in situations, such as patients' second and subsequent hospital appointments, where, according to trust policy, they should not. This is due to pressure from hospital staff and patients, and a feeling by the link workers that by refusing to interpret, they are breaking the trust of the community. Somali community leaders have complained that the Somali link workers no longer interpret, contending that they were losing a service. The underlying causes of much of this pressure are the under-resourcing of the current interpreting service and poor communications systems between hospitals, primary care, link workers and patients (section 7.2). Health link workers have also become involved in other areas, such as advising asylum seekers on issues such as buying food, which are outside the job description but which fulfil a real need not currently fulfilled by other agencies.

Staffing levels

The health link workers and other key players report that there are too few link workers working too few hours for the communities they serve. For example, two full-time health link workers serve a community of around 4,000 Somalis, the majority of who do not speak fluent English. The female South Asian health link workers, employed to support women's health services, report the need for male health link workers to undertake health promotion and promote access for men, who do not always listen to women. All the health link workers expressed a desire to undertake more health promotion and outreach work and reported that this was also the wish of the communities. There is a need already in discussion by Liverpool Central West PCG for male and female Arabic speaking health link workers.

Management and Support

The current health link worker manager and other respondents identified that the support and management structures in place for health link workers could be improved, with suggestions that the service needs a dedicated manager with expertise in ethnicity and health. Some respondents also expressed concern that the link workers had not received enough training in their current role as health promoters, and may not be sufficiently competent to carry out some of the roles that they have been assigned. However, the link workers expressed satisfaction at the training they have received, and confidence in delivering health information messages.

Service Monitoring

The health link workers complete an activity log, but the information collected is vague and as a result, the service activity data is of limited use. A client satisfaction questionnaire for health care workers has recently been devised, but relates only to the role of the link workers as interpreters. There are therefore no effective service monitoring systems in place.

Pay

Although not identified as an issue either by the health link workers or others, it should be noted that the link workers are currently paid at the relatively low Administrative and Clerical grade 4 (A+C4), which may not be commensurate with their skills and responsibilities. There has never been an evaluation of the health link workers' role in relation to pay.

7.4 Bilingual staff

7.4.1 Service provision

Several primary health care staff members in Liverpool are bilingual in local community languages. These include a GP who speaks Arabic and another who speaks Bengali.

Issues identified

Lack of choice for patients

The link workers expressed concern that, due to the current lack of interpreting services, members of ethnic minority communities feel obliged to use a GP who speaks their language, even if they are not satisfied with the service, for instance because the practice does not have a female GP.

7.5 Translated Information

7.5.1 Health information for patients at GP practices

A variety of translated health information materials are available free of charge to GPs from Liverpool Health Promotion Service. Languages include Arabic, Bengali, Chinese, Gujerati, Hindi, Punjabi, Somali and Urdu. They also have a selection of materials in English written specifically for the African-Caribbean community. Subjects include coronary heart disease, women's health, sexual health, pregnancy and parenting, mental health, diabetes and substance use. Not all subjects are available in all languages. Some leaflets are free to the Health Promotion Service from the Department of Health or pharmaceutical companies, others have to be paid for and are in shorter supply. Liverpool Health Promotion Service also produces some material in house, including a tape on diabetes in Chinese and has produced a policy/ guide for anybody wanting to translate health promotion material.

Liverpool Health Promotion Service is working with Liverpool Central West PCG to develop information on cytology in different languages. They are developing posters, leaflets and bilingual audio cassettes in Punjabi, Hindi, Bengali, Urdu, Cantonese, Somali, Arabic and Chinese. The translation was undertaken jointly by Liverpool Translation and Interpreting Service and the health link workers. Some of the health link workers spoke on the tapes, but others did not want to. A local Chinese Talking Newspaper is produced from Liverpool Voluntary Society for the Blind, where, because they have access to recording equipment, translated cassettes on diabetes and women's health have also been recorded.

Liverpool Central West PCG has paid for information on breast awareness to be translated into a range of languages and illustrated with multi-cultural images. Breast awareness information has also been recorded onto audio cassette and similar information on breast screening and assessment is planned. These resources will be available from some GP surgeries, libraries, the Health Promotion Resource Centre and the health link workers.

NMCT's Asylum Seeker Support Team has collated details of translated information available from others working with asylum seekers throughout the country.

7.5.2 Information on medicines for patients at pharmacies

The prescribing advisor at Liverpool Central West PCG is currently working to obtain some translated information on medicines for pharmacies.

7.5.3 Information about the NHS and local health services

NMCT Asylum Seekers Support Team is producing a brochure explaining how to access health care and detailing relevant local agencies and health organisations. There are plans to make this available in languages commonly spoken by asylum seekers in Liverpool. Princes Park Health Centre has produced a brochure of their services in two languages and audio cassettes in other languages.

7.5.4 Radio broadcasts

The Friends Information Centre have recorded programmes for transmission on BBC Radio Merseyside, for example, an eye specialist gave talks in English that were translated by workers into different Asian languages. This was undertaken as part of the South Asian Heart Health Project, funded between 1996 and 1999.

7.5.5 Community health libraries

Liverpool Central and Southern Community Health Council and Toxteth Health and Community Care Forum both have public libraries containing some health information in community languages other than English. Toxteth Health and Community Care Forum also produces a bimonthly health information newspaper, 'Voices', with sections translated into four local community languages, which is delivered to 34,000 homes in Granby, Abercromby, Arundel and Smithdown.

7.5.6 Developments in secondary care

The Royal Liverpool University and Broadgreen Hospitals NHS Trust will shortly be employing a patient information co-ordinator, part of whose remit will be the provision of information to patients whose first language is not English. They are awaiting the delivery of welcome signs in various languages and talking signposts that speak in different languages.

Issues identified

Written information

The translation of written materials is expensive and difficult, as there is often no equivalent word for medical terms in other languages. Members of some communities, including many of the older Somali population, are unable to use translated written information because they are not literate in their own language. Hospitals report a poor uptake of translated materials. A model suggested for providing translated information to a patient about their condition was to record on audio cassette the information provided through an interpreter at the consultation. However, asylum seekers and others on very low incomes may be unable to make use of this type recorded information, as they cannot afford to buy cassette players.

Gaps in service provision

The number of languages and the volume of materials translated are limited. Pharmacies in particular are short of translated information on how to take medicines, a problem compounded by the fact that interpreters are not available at pharmacies.

All call and recall letters for breast screening and cytology are sent out in English. Lack of ethnicity profiling of patients and poor capacity of the computer systems run by the Breast Screening Unit and Central Operations Group mean that the introduction of letters in different languages would be difficult.

Data protection

Patients now have a legal right to receive copies of any letters that are written about them. There has not yet been any guidance from central government on whether and how that information should be provided to people who do not read English or whose English is poor. If referral letters need to be translated, it could be expensive and difficult.

7.6 Culturally appropriate services

7.6.1 Service provision

NMCT employs an equality advisor for issues of equality regarding minority ethnic and disabled staff and patients. The trust provides compulsory cultural awareness training for all their staff, and equality awareness training as part of the compulsory staff induction programme. In addition, certain professional groups receive extra cultural awareness training, depending on the job they do. The NHS programme 'Positively Diverse' was piloted by NMCT. A system has been set up in co-operation with the Citizen's Advice Bureau, whereby staff subject to harassment and bullying can obtain support. The trust publication 'Communications for All' contains a list of community organisations of relevance to patients from minority ethnic groups.

Issues identified

Availability of female GPs

Liverpool Central West PCG, which covers over half of people from minority ethnic communities in Liverpool, is poorly served with female GPs. Twelve of the twenty-five practices in the area are male single-handed, and one quarter of patients do not have access to a female GP. This may be adversely affecting the health care of people from ethnic minority groups, especially Muslim women.

Quality of primary care services

Concern has been expressed about the variable quality of primary care services in the area. In addition, services are strained because of the high levels of deprivation in the area, including that of the large numbers of recently arrived asylum seekers.

Cultural awareness training

There has been little cultural awareness training undertaken with GP practice staff. Training is difficult to deliver within the primary care setting, as cover must be found for staff during training. In addition, GP practices may find it difficult to access such training; NMCT has received some requests for cultural awareness training from GP practices but is unable to provide this.

Use of local resources

Attempts to recruit people from minority ethnic communities to become volunteers within the health services, become a representative on a patients' council or complete a patient satisfaction survey have been relatively unsuccessful, even using translated materials and outreach with community groups. A number of people from refugee populations in Liverpool were health professionals in their own country, but are unable to practice as their qualifications are not recognised in Britain. These people represent an untapped resource, either as potential health professionals or for roles such as health advocacy and health promotion.

7.7 Special projects and services

7.7.1 Muslim and Multi-cultural Women's Health Clinic

NMCT run a Muslim and Multi-Cultural Women's Health Clinic at Abercromby Health Centre. The clinic has an all-female staff and has three female health link workers in attendance, speaking Arabic, Somali, Hindi, Punjabi, Bengali and Urdu between them. Changes were made to ensure that no males walked along the corridors while the clinics were in operation, and hygiene equipment was added to the toilets to comply with Muslim cultural requirements. An evaluation of the service, undertaken by Chester and Halton Community NHS Trust, showed that the service was necessary and well utilised³⁶

7.7.2 Link Clinic - Liverpool Women's Hospital

There is Link Clinic at Liverpool Women's Hospital where ante-natal care is provided by midwives supported by the NMCT health link workers. A consultant at the hospital provides a service for women with problems caused by female genital mutilation.

7.7.3 Centre for Inherited Blood Disorders

The Centre for Inherited Blood Disorders at Abercromby Health Centre is run by a Black health visitor and has access to the health link workers. It offers screening and counselling to those at risk of inherited blood disorders.

7.7.4 Specialist diabetes nurse

NMCT are applying for funding to employ a diabetes specialist nurse for ethnic minorities, to be based at Abercromby Health Centre.

7.7.5 Building Bridges (a mental health service)

Building bridges is funded through the HAZ innovation fund and based at Alder Hey Hospital. It provides a mental health service for children from minority ethnic groups and their families. It aims to provide an accessible, culturally appropriate and non-stigmatising service, with availability of translated information, interpreters and bilingual staff. The service provides preventative work for the general population, including work with housing and education

services, direct work with families, including assessment, intervention and work with other agencies where appropriate, and consultation and training for staff of other agencies.

7.7.6 Health promotion projects

Liverpool Health Authority funded the South Asian Heart Health Project from March 1996 to March 1999, supplemented with funds from the British Diabetic Association, Health Education Authority and Active for Life. The project included work on diabetes, as the two conditions are linked. The project employed two paid outreach workers working part-time and six volunteers who spoke Bengali, Hindi, Punjabi and Urdu between them. The objectives of the project were to promote physical activity and a healthy diet, encourage regular health check ups, and provide information on heart disease and diabetes in different languages using a variety of methods. Work undertaken included five physical activity and sports centre open days, two physical activity and sports centre open weekends and four series of culturally appropriate exercise opportunities. There were also twelve bilingual radio programmes, articles in Asian newspapers, exhibitions, seminars and training events. Approximately 1,400 people participated in the project. An evaluation undertaken by the Liverpool Public Health Observatory indicated that the project was successful in⁸:

- Identifying barriers to South Asian people accessing exercise facilities, leading to the provision of new services such as women only swimming sessions.
- Increasing the use of exercise facilities by South Asian people.
- Increasing the attendance of South Asian people at the cardiac rehabilitation project.
- Informing South Asian people about health and leisure facilities and how to look after themselves.

Various projects were undertaken between 1997 and 1999, funded through the North West Diabetes Development Fund. Bilingual support workers from the Yemeni, Somali and African-Caribbean communities were employed to identify people with diabetes and organise diabetes education sessions for their communities. A bilingual Chinese support worker was employed to work with health care professionals, community members and the Chinese Talking Newspaper to develop audio cassettes about a person's experience of having diabetes and the health services available. South Asian diabetes self-help groups were set up, using three bilingual volunteers, and Bangladeshi 'Cook and Eat' clubs, where a dietician trained two local women from the Bangladeshi community to run their own healthy cooking clubs. Members of the Chinese, South Asian, African-Caribbean and Arabic communities were brought together to design a visual teaching aid called the Diabetes Art Box. Evaluation showed that the diabetes projects were successful in raising awareness of diabetes amongst ethnic minority communities.

A Multi-Cultural Diabetes Steering Group still meets and undertakes work depending upon the funding available, for example, they have recently organised diabetes health promotion days for the Chinese Community at St James Health Centre.

The Friends Information Centre currently employs a health advisor and a benefits advisor for the South Asian communities, both working part-time. The centre offers accommodation and secretarial support to any health project for the South Asian communities. In this capacity, they supported the South Asian Heart Health Project and were involved in bidding for funds from the British Diabetic Association for diabetes education projects within the South Asian communities. The Literary Circle of Friends, the organisation that initially set up the Friends Information Centre, supported the South Asian Heart Health project by producing posters, for example, pictures of hearts with Urdu poetry over them.

Liverpool Health Promotion Service have provided and supported a range of health promotion activities for minority ethnic groups. They have previously collaborated with the Leisure Services

Directorate of Liverpool City Council to facilitate access to exercise for people from minority ethnic groups. Sports centre open days were held for Indian, Pakistani and Bangladeshi communities, and single sex exercise sessions were developed for women from these communities, with all female instructors and the windows blacked out so that men could not see in. Several exercise days were organised for the Chinese community at Everton Park Sports Centre. Single-sex exercise sessions for Somali men and women were held at Park Road Sports Centre; transport was also provided for this group, as many of the women had difficulties in walking resulting from female genital mutilation or experience of harassment on the street. Tai Chi sessions were held for African-Caribbean people. Joint Somali-Yemeni exercise sessions are now held at Park Road Sports Centre.

Liverpool Health Promotion Service and the Leisure Services Directorate of Liverpool City Council collaborated on the Community Sports Leaders Award, provided free of charge to members of minority ethnic communities. Twelve candidates have qualified so far, nine of them female, and have received their awards at a ceremony held in St George's Hall. This qualification will allow them to run sports activities from their own community centres.

Liverpool Health Promotion Service is currently working to increase awareness of breast, cervical and skin cancers and to increase the uptake of screening for breast and cervical cancers. They have worked with local communities through an interpreter, for example by providing a seminar for the Somali, Yemeni, Chinese and South Asian communities on cytology and breast awareness. Seminars were organised with the help of community leaders and health link workers. With the Somali community, they also discussed female genital mutilation, a very sensitive issue, with input from a local Black health visitor. Seminars were each attended by 15-20 women. WHISC has also run courses on women's health for women from minority ethnic groups at Blackburne House Centre for Women. However, these have been poorly attended, with only six to ten women attending most sessions.

Toxteth Health and Community Care Forum become involved in health promotion and health improvement projects as the needs arise. For example, they have consulted with Liverpool City Council Leisure Services Directorate to obtain single-sex keep-fit and swimming sessions for older Somali women at the local sports centre. The forum provides transport to the sports centre. They are working with Liverpool Football Club and Greenbank Disabilities Sports Project to provide football and sports training for young Somali men, responding to concerns about members of this group becoming depressed. They also assisted in the setting up of a West African Elders Club, helping to reduce isolation in this group of people.

Project 8, a drug assessment and support service based in the Liverpool 8 area, has undertaken drugs awareness education with young people in the Liverpool 8 area, including Black British, Somali and Yemeni groups.

Lay food workers, funded through Merseyside Health Action Zone (HAZ), currently work with minority ethnic groups to demonstrate healthy eating and cooking. This includes presentations to asylum seekers on how they can spend their food vouchers in the local supermarkets.

Issues identified

Need for continued health promotion around diabetes and heart disease

The health link workers and Friends Information Centre identified the need for continued health promotion around diabetes and heart disease for the South Asian community. In particular, that a male worker was needed for health promotion with South Asian men and that training was needed for chefs in Asian restaurants on how to prepare healthy food.

7.8 Support for asylum seekers and refugees

7.8.1 NMCT Asylum Seeker Support Team

NMCT Asylum Seekers Support Team is funded partly through Merseyside Health Action Zone (HAZ) and partly through mainstream funds. The service employs a manager, secretary and clerical assistant, one full-time associate GP based at Princes Park Health Centre, a health visitor working two days per week and a multi-lingual advocacy worker, speaking French and Russian and two part-time public health nurses. Additionally the service funds additional TB Visitor hours and a part-time clerical assistant to support the TB Visitors.

The objectives of the team are to:

- Facilitate access to health services for asylum seekers.
- Provide health education, health promotion and advice to asylum seekers.
- Provide support for primary care teams across Liverpool, including training and education, clinical sessions and provision of support material.
- Provide guidance on the delivery of services for asylum seekers.
- Liaise with specialist health teams and organisations, sharing best practice and developing the service.
- Liaise and co-ordinate work with statutory and voluntary organisations involved in the support of asylum seekers.
- Evaluate the service provided to asylum seekers within primary health care and assess the pressures on primary health care teams.
- Establish and support public health strategies.

The service liaises with many other relevant organisations, including local churches, Liverpool City Council Asylum Support Team, housing, social services, police, refugee action, education, immigration, voluntary agencies, etc.

The service has produced an asylum seekers' health information pack for primary health care teams¹⁴. It is a comprehensive guide containing sections on general information, communicable diseases, common tropical diseases, women and children, teeth, feet and eyes, local specialised services, mental health, support agencies, education, background information on the origins of asylum seekers and guidelines on issues such as using interpreters and registering births.

Currently the service are preparing an information booklet for asylum seekers in Liverpool explaining the NHS, how to access services, the role of primary health care teams and details of local services and agencies. This will be available in languages commonly spoken by asylum seekers in Liverpool.

The TB Visitors attempt to screen all asylum seekers, mainly by contacting patients at home. An HIV Strategy for asylum seekers has been established, which includes a pilot for HIV testing in the community, direct contact with patients arriving from areas of high incidence of HIV, supply of condoms to general practice and asylum seeker hostels, HIV outreach sessions and education of primary health care teams to raise awareness and encourage opportunistic HIV education and support.

7.8.2 Mersey Live PCG

Mersey Live PCG has funded a full-time practice nurse and a half-time GP to work with asylum seekers at a practice where around 500 asylum seekers are registered.

7.8.3 Liverpool Health Authority

Liverpool Health Authority maintains a spreadsheet resource listing all the asylum seekers known to live in the area and their addresses. This assists primary health care services to keep in touch with asylum seekers, facilitating continuity of care.

7.8.4 Family Refugee Support Project

This HAZ funded mental health project is open to any refugee family whose ability to function is affected by their experience of persecution and exile. The project accepts referrals from a range of sources including GPs, health visitors, refugee organisation and teachers. Families accepted onto the project are offered an allotment, a set of gardening tools and plants, with therapeutic support to talk about their current and past situation and help them feel more settled in this country. Families may use the allotment for up to two years, after which they may continue as senior members helping others new to the project and perhaps continuing with the allotment without therapeutic support.

Issues identified

Difficulties in obtaining benefits and registering births

Like others on a low income, asylum seekers are able to access free dental and optical services if they have completed an HC1 form (entitlement to NHS services) within the last six months. HC1 forms are 16 pages long and available only in English. In order to receive maternity benefit, an asylum seeker must register the birth within two weeks. However, this is difficult because the initial booking with the registry office must be made through Liverpool Direct, Liverpool City Council's telephone and drop-in access service, which currently has no interpreters, and the Registrars Office also currently has no interpreters. The father must be present if his name is to appear on the certificate and, due to mistakes in the system, husbands are not always living in Liverpool.

Provision for women and babies

Asylum seeker benefit systems do not include provision for powdered baby milk for women who are HIV positive, or for nappies. Sometimes, when a baby is delivered to a non-English speaking asylum seeker at the Women's Hospital, they cannot be discharged because they have nothing for the baby and have not been given any information, as an interpreter has not been found. Also, if the woman has been living in a hostel, she is put into alternative accommodation after the birth, where she may be left alone with the baby.

Maintaining contact with asylum seekers

There are often problems in maintaining contact with asylum seekers, making it difficult to target health services and maintain continuity of care. Much of the information received from the Home Office is late or inaccurate and some asylum seekers never arrive in Liverpool or move away by choice. Others change their names for immigration reasons, or confusion arises over spelling (especially when translating names from another script) or name order.

Distortion of healthcare priorities

The first priority for all asylum seekers is their claim for asylum. This can distort their health care priorities, for example, it is not effective to screen new arrivals before they have received some information about the NHS, including its independence from the Home Office, otherwise they may exaggerate or hide health problems.

The living conditions of asylum seekers

The conditions under which asylum seekers live are likely to adversely affect their health. For example, there have been problems with the hostels not providing enough food, water or washing facilities. Asylum seekers whose claim is successful are given 14 days to move out of asylum seekers' accommodation, which can result in homelessness or housing in council emergency accommodation. Asylum seekers whose claim is not successful often do not leave Liverpool, either because they do not want to, because their travel warrant does not arrive, or because they get lost on the way. These people have no access to benefits and often become homeless. All asylum seekers are housed in already deprived areas, which can affect both their health and, through the strain on services, the health other people living in the area.

Most asylum seekers are existing on a very low income, consisting of 70% of the current level of income support in vouchers, redeemable for food, clothing, telephone calls and transport costs, and a small amount of cash (£10 per week). Asylum seekers are able to apply for a one-off maternity grant of £300 within a period four weeks before and two weeks after the birth of a child. The grant often takes many weeks to arrive, leaving the family without adequate income to feed and clothe the child.

Special needs of some asylum seekers and refugees

There are specific health problems faced by asylum seekers and refugees, caused by the experiences that led them to become refugees. Because asylum seekers are new to the area, there is a lack of specialist services available, especially for those who have lived through very traumatic events.

Asylum seekers as a resource

Some asylum seekers have bilingual and/or health care skills that could be used to help other asylum seekers and people from minority ethnic groups. However, because of the rules on asylum seekers working and claiming benefits, issues of confidentiality, and the fact that some qualifications obtained abroad are not recognised in Britain, these skills have not been utilised.

7.9 Social support and social care services

7.9.1 Irish Community Care

Irish Community Care provides two health related outreach projects:

- Outreach for Irish people who are homeless and experiencing problems with their mental health and substance use. This is funded by jointly by Crisis and Liverpool Health Authority.
- Outreach for older Irish people who are in poor health and living in unsuitable accommodation. Initial assessment is provided and access to existing services is facilitated. This service is funded by the Irish government.

Irish Community Care also has a youth worker, funded by the Irish Youth Foundation and CALM (Campaign Against Living Miserably) and social groups for older Irish people. They work with PSS to provide supported housing for older Irish people with an Irish support worker.

Irish Community Care are also working with Liverpool City Council to create a forum through which the conditions of Irish travellers living in Liverpool can be improved, and are in the process of developing a group for socially excluded Irish people, particularly the homeless.

7.9.2 Liverpool Voluntary Society for the Blind

Liverpool Voluntary Society for the Blind (LVSB) employs a rehabilitation worker for clients from Black and other minority ethnic groups. A culturally appropriate service is provided, for example, kitchen skills are taught in such a way as to be appropriate to religious needs. Gender issues may also be apparent when working with Muslim women, in which case work with the family is especially important. Where a client's first language is not English, they work closely with health link workers and interpreters, making sure that the same interpreter is used on each visit. LVSB is working with Liverpool City Council to provide training for the interpreters to familiarise them with the client assessment process. The society also runs African-Caribbean and Chinese social groups, who also provide input to LVSB about what services they would like.

7.9.3 Project 8 (drug assessment and support)

Project 8, based in the Liverpool 8 area, provides a culturally sensitive drug assessment, referral and support service for people living in the area, especially those from visible minority groups. They are currently training eight Black people from Liverpool to become community drugs workers, to address issues of access to drugs services for Black people. The project is funded by Liverpool Health Authority, Liverpool Social Partnership, the National Drug Treatment Agency and through donations from the local community.

7.9.4 Mary Seacole House (mental health support)

Mary Seacole House, funded jointly by Liverpool City Council and Liverpool Health Authority, is a drop-in day centre primarily for people with mental health problems who encounter racism and discrimination in their day to day living. The centre provides support and advice on practical and emotional matters. It also has cooking, washing and showering facilities. Once a month the centre holds a chiropody service (provided by NMCT), welfare advice clinic and legal advice clinic. A community pharmacist visits weekly to advise on medication. The centre also offers group activities, education and training and massage and aromatherapy.

7.9.5 Services for refugees and asylum seekers

Refugee Action employs four multi-lingual advocacy workers who visit asylum seekers in the community and assist with problems such as accommodation. Liverpool City Council's Asylum Support Service helps asylum seekers to connect with essential services including primary health care, schools and emergency services. To facilitate this, the service employs twelve bilingual support workers at the reception centre and six in the community. They have a strategic plan to recruit more staff with the relevant language skills. There is a strategy due out in autumn 2001 on how refugees who have been allowed to stay can be integrated into the mainstream community, for example by accessing education, training and employment.

7.9.6 Liverpool City Council Directorate of Social Services

Clients of Liverpool City Council Directorate of Social Services have access to the services of the city council's interpreting services and, in cases such as assessment of disabilities, the support of the health link workers. The directorate also has a specialist social services team for the Chinese community. Granby House nursing home was opened by Liverpool Social Services Directorate in 1995 to provide care for elderly people from minority ethnic communities. The home provides culturally appropriate services and language support.

Issues identified

Problems faced by some groups of Irish people

It has been identified by Irish Community Care that there are increasing numbers of young Irish people moving to Liverpool because they have been excluded from Ireland. These young people do not have the option of returning to Ireland, are often in poor health and need help to resettle. Irish community care has also identified problems faced by Irish travellers in Liverpool. Conditions at the fixed travellers' site are poor, and temporary visitors face problems in accessing services such as schools and health care. These issues are beginning to be addressed through the Travellers Forum.

Access to language support within Liverpool City Council's own services

Liverpool Translation and Interpreting Service reported concern that the majority of its work is undertaken within health services, leading to the conclusion that its own non-English speaking clients may not be receiving the language support they require. Liverpool Central and South Community Health Council reported that Granby House Nursing Home has been unable to recruit sufficient bilingual staff to ensure effective communication with residents. The NMCT Asylum Seekers Support Team reports difficulties in accessing interpreters for the registration of births and other services accessed through Liverpool Direct.

8. RECOMMENDATIONS

Recommendations were devised by comparing the needs and current services identified in Liverpool with models of good practice identified through the literature review.

8.1 *Needs assessment, planning and strategy*

- 8.1.1 As the majority of people from minority ethnic groups in Liverpool live within the area to be served by Central Liverpool PCT, this body should be responsible for commissioning and providing ethnic health services within primary care throughout Liverpool.
- 8.1.2 An overall Ethnic Health Strategy should be developed by Central Liverpool PCT, following consultation with relevant community groups and other health care providers, through an ethnic health forum. The strategy should take particular account of the need for communication and continuity of care at the interface between primary and secondary care.
- 8.1.3 To support the development and implementation of the Ethnic Health Strategy, an ethnic health co-ordinator and support staff should be appointed. The ethnic health co-ordinator should be reasonably senior with experience of ethnic health, management and/or commissioning health services in this area (see appendix iii for an example job description).
- 8.1.4 The ethnic health forum should continuously plan and monitor health services. It should form links with organisations outside the health services to influence the provision of services affecting health and access to health care, for example, provision of English lessons, bilingual support workers and suitable housing.
- 8.1.5 Each PCT should develop an Equalities Programme similar to that currently employed by NMCT, overseeing issues of ethnicity, disability, gender, etc. The Equalities Programme should be linked to a Communications Strategy and to the work of the Patient Advice Liaison Service (PALS), which will replace the Community Health Councils in each PCT.

8.2 *Development of primary care services*

- 8.2.1 The development of primary care services in areas with the highest proportion of patients from ethnic minority groups should be a priority, especially as these areas are disadvantaged in many other ways.
- 8.2.2. All practice staff should be trained on racial equality, cultural awareness and how to use health link workers, interpreters and the telephone interpreting service. The health link workers and interpreting service could provide input to this training. If possible, the PCT should pay for cover while the training takes staff away from their post.
- 8.2.3 Using newly available incentives, efforts should be made to recruit more female GPs to areas with a high proportion of patients from minority ethnic groups and, if possible, recruit primary health care staff with language skills.
- 8.2.4 Information and communication technology capabilities should be developed in readiness to access the National NHS interpreting system, to aid identification of patients who require language support and to communicate this with other providers.

8.3 *Development of interpreting services*

- 8.3.1 Interpreting services need to be developed in response to the number of non-English speakers who have recently arrived in Liverpool, the number of languages spoken by the recent arrivals and observed upwards trends on the use of interpreters in primary care.
- 8.3.2 As the majority of the work currently undertaken by Liverpool Translation and Interpreting Service is within health service settings, the major health care providers should have some input into its development and management. This may include providing specific health related training to interpreters where a need is identified. As the health of non-English speakers can also depend on the availability of interpreters for council-run services, for example, in registering births so that maternity benefit can be obtained, the city council and health services may consider managing the service as a partnership.
- 8.3.3 Liverpool Translation and Interpreting service should receive additional funding so that it is able to:
- Provide more interpreters
 - Increase the quality of the service, in particular the reliability of the interpreters
 - Recruit interpreters who speak languages new to Liverpool, such as Kumanji
 - Implement effective monitoring systems
 - Develop more responsive ways of working, such as telephone interpreting in some circumstance
 - Evaluate the uptake and usefulness of increased services provision
- 8.3.4 The interpreting service should develop a unified system for booking interpreters in all settings. Protocols on the use of interpreters should be strengthened through consultation, dissemination and monitoring.
- 8.3.5 Depending on the funding available, all practices, or practices with a significant number of non-English speaking patients, should have access to a national telephone interpreting system, funded by Central Liverpool PCT for economy of scale. Language cards should be available on the reception area of every practice, to identify the languages spoken by new patients.
- 8.3.6 Consideration should be given to providing pharmacies in areas with significant non-English speaking populations with access to a national telephone interpreting service, so that medicines can be dispensed safely.
- 8.3.7 A volunteer interpreter bank could be kept, and list of volunteers kept up to date, although they should be used only where it has not been possible to find a professional interpreter. Although there are potential issues of liability when using unqualified volunteers, the potential problems involved in having no interpreter are even greater. Consideration should be given to arranging simple assessments on the competence of volunteers and to providing training, including the need to interpret everything accurately and to maintain confidentiality. If shortages of interpreters persist, consideration could be given to arranging training free of charge to volunteers so that they can become qualified interpreters.

8.4 *Development of the health link worker service*

- 8.4.1 Additional health link worker time should be made available to the communities. Needs were identified for a male South Asian link worker, male and female Yemeni link workers, and an additional Somali link worker.
- 8.4.2 The link workers' time should be freed for health promotion work by making the interpreting service more reliable and improving communications so that patients and link workers are informed that an interpreter will be available at appointments.
- 8.4.3 The communities served by the health link workers would benefit from the provision of generic link workers facilitating access to other essential services. These could be employed through Liverpool City Council or voluntary groups rather than the PCT.
- 8.4.4 The role of the health link worker should be made clearer and they should be fully involved in primary care team meetings (this recommendation was also made in the recent review of the link worker service). The health link workers' roles and pay should be reviewed to ensure their status as professionals. Responsibility for the supervision and management of the link workers should rest with the ethnic health co-ordinator.

8.5 *Provision of translated information*

- 8.5.1 Central Liverpool PCT will require access to more translated information than is currently available in Liverpool. In order to make use of economies of scale, the ethnic health co-ordinator should liaise with other organisations throughout the country regarding the sharing of translated materials, building on the work already undertaken by the NMCT Asylum Seeker Support Team. The ethnic health web portal currently being developed by the North West Public Health Observatory could be used to facilitate the exchange of such information.
- 8.5.2 Further use should be made of information recorded on audio cassette, which may be cheaper to produce than printed materials and more accessible to communities with low rates of adult literacy. Some patients, particularly asylum seekers and others with a very low income, may not possess a cassette player and arrangements will need to be made for them to access one.
- 8.5.3 Translated information is particularly important in pharmacies. Medicine labels with translated instructions on how the medicine should be taken should be either bought or produced locally and made freely available to pharmacies.
- 8.5.4 Services sending out standard letters, such as those recalling women for cervical cytology, should consider developing and using standard letters in common community languages, such as Somali, as well as English.
- 8.5.5 The need for translated letters and other materials should be identified through the sharing of ethnicity profiling data collected in primary care. This will require investment in information and communication technology systems as well as an initial investment in translation. The need for translated materials should be taken into account in any information management and technology plans.

8.6 *Additional support for refugee and asylum seeking populations*

8.6.1 To further support the asylum seeker and refugee populations in Liverpool, and to prevent their presence impacting on health care provision for other communities living in the area, additional funding should be made available. The PCT or health authority may need to bid for funding from external sources. This additional funding should be used to:

- Provide extra payment to practices registering a high number of asylum seekers, to support standards of care such as adequate consultation time using an interpreter. Such a scheme is currently being developed.
- Develop or attract additional, specialist services, for example, a mental health service specialising in trauma and delivered in relevant languages (already identified as a need amongst the Somali community).
- Improve information systems used to maintain health service contact with asylum seekers.

8.7 *Ethnicity profiling*

8.7.1 The ethnicity profiling system developed at Princes Park Health Centre³⁶ should be extended if possible to all practices within Central Liverpool PCT, or at least to all practices with a significant population from minority ethnic groups. The information should be used to identify patients who need an interpreter, link worker and/or translated information and to identify religious, cultural and potential health needs, for example for sickle cell screening. Mechanisms should be developed to effectively share that information with other providers of care. The information should also be used on a population level to monitor and continually assess the health needs of minority ethnic populations in the area.

8.8 *Collation of local resource information*

8.8.1 Information on services and projects for people from minority ethnic groups, relevant community organisations and local people with skills or expertise in ethnic health should be collated and made available to primary care staff. This information may be presented alongside information on how to access an interpreter and background reference material such as the religious and cultural needs of different communities, festival dates, etc. perhaps in a ring binder so that it can be updated

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APPENDIX i

North Mersey Community NHS Trust Central Locality

Abercromby Health Centre, Grove Street, Liverpool L7 7HG

Tel: 0151 708 9370

INTERPRETING SERVICES MONITORING FORM

Please fill in this form when an interpreter has completed his/her assignment and return it to Sheila Scott, Training & Development Manager at the above address.

1. Name of organisation:
 2. Name of department:
 3. Date interpreter was used:
 4. Language required:
 5. Ethnic origin and gender of client/patient:
 6. How was the need for an interpreter identified?
 - 1 By the client/patient
 - 2 By the interpreter
 - 3 By client's friend/relative
 - 4 By G.P.
 - 5 Hospital staff
 - Health Professional
 - 6 Do not know
 7. When was the request for an interpreter made?

Before the appointment On client's/patient's arrival Do not know
 8. Did the interpreter arrive on time? Yes No If no, how late?
 9. How did you rate the performance of the interpreter?

Excellent Good Satisfactory Poor Bad
 10. Did you find the interpreting service useful? Yes No

If no why?
 11. Any comments:
- Name: Designation:
- (Please print)

APPENDIX ii

Assessment for self-employed interpreter

Name:		Country of origin:	
Address:			
Contact no:	Tel: Fax:	Mobile: E-mail:	
Language:		N.I. No:	

Academic Achievement					
Qualifications			Marks	Proof	
Full member of NRPSI	(Membership no:)	10	Y	N
Interim member of NRPSI	(Membership no:)	7.5	Y	N
DPSI (full diploma, any option)				Y	N
Post-graduated Diploma/Degree in Translation & Interpreting from university				Y	N
A grade at IAA assessment				Y	N
Full member of IOL and/or ITI				Y	N
DPSI (letter of credit - interpreting passed, any option)			5	Y	N
Recognised language degree from university				Y	N
B grade at IAA assessment				Y	N
Social Science degree from university (for ESL applicants only)				Y	N
Reference with language assessment from Police or British Council				Y	N
Non assessed member of NRPSI	(Membership no:)	2.5	Y	N
C grade at IAA assessment				Y	N
Non Social Science degree from university				Y	N

Level of Experience				
Over 5 years	5	NOTE: Evidence is required to prove the level of experience (eg. Letter from recognised agencies or relevant invoices.	over 1700 hours of interpreting	5
Over 4 years	4		over 1200 hours of interpreting	4
Over 3 years	3		over 800 hours of interpreting	3
Over 2 years	2		over 500 hours of interpreting	2
Over 1 year	1		over 300 hours of interpreting	1
Less than 1 year	0		Less than 300 hours of interpreting	0

TOTAL MARKS:	DATE:
Calculated by:	Verified by:
Professional Indemnity Insurance Policy no:	

BRADFORD CITY PRIMARY CARE TRUST**JOB DESCRIPTION**

POST TITLE:	EQUALITY AND DIVERSITY CO-ORDINATOR
SALARY:	£28,653 - £35,185
RESPONSIBLE TO:	Director of Nursing & Service Development, City PCT
ACCOUNTABLE TO:	Director, Bradford Health Action Zone
LOCATION:	City PCT, Bradford

PURPOSE OF POST

Bradford Health Authority and the four Primary Care Trusts serving Bradford District are committed to ensuring that all health care services within the District are accessible, appropriate and sensitive to the needs of the population, recognising the diversity in relation to race, colour, nationality, ethnicity, gender, sexual orientation, religion, age, disability, geography or social background.

The aim is to improve health and healthcare and to be a fair employer. This post aims to focus action to tackle inequalities in a strategic way, and to use the influence of the health community to make a difference for the people of the District. The postholder will need to ensure that the organisations are responsive to the issue of equality deficits.

The post-holder will be the expert adviser on diversity and equality issues to Bradford Health Authority, and the four Primary Care Trusts, in the first instance. The role will be to facilitate, co-ordinate and, where appropriate, lead on the strategic implementation of current Equality and Diversity strategies. This will involve collaborating with the Authority's Executive Group, PCT Boards and Professional Executive Committees, lead Directors, the Health Equality Action Team and the cross-sector 'Diversity Partnership' in order to co-ordinate the implementation, evaluation and revision of the Equality and Diversity Strategies to improve health, health care and employment-related opportunities.

DUTIES:

1. To develop the strategy on equality and diversity in partnership with the other Primary Care Trusts, the Health Authority and other partners and link the operational needs of the health community in Bradford District.
2. To advise and assist the Chief Executives and Boards of the Health Authority and Primary Care Trusts in the issues of equality and diversity.
3. To co-ordinate and progress the implementation of the Equality and Diversity Strategies to a high standard.
4. To facilitate the pooling of resources and, where appropriate to deliver joint working.
5. In conjunction with the Diversity Partnership, to identify and develop opportunities for:
 - Joint provision of services
 - Workforce development
 - Appropriate community/patient participation in service development, delivery and scrutiny
6. To act as a specialist resource on equality and diversity issues as they relate to health and social care, health inequalities and other related partnership work, through the strengthening and developing of networks.
7. To liaise with lead managers in the Hospitals' Trusts, Community Trust and Social Services concerning their equality and diversity strategies / practice / standards.
8. To act as a 'welcome challenger' to the Authority upon all issues relating to equality and diversity across the district.
9. To assist in producing internal standards / targets for improved performance and to assist and advise upon effectively meeting NHS performance standards / targets.
10. To provide an annual report to the Health Authority and PCT Boards on the progress against relevant performance targets.
11. To ensure that all business planning, policy development and service delivery emanates from continuous audit of 'Equality deficit'.
12. To support at all times the district wide agenda on tackling health inequalities, particularly with regard to service development.
13. To act as a resource for workforce planning, employment issues / practices.
14. To co-ordinate any board and staff training and development requirements upon equality and diversity issues in conjunction with service Development Managers.
15. To manage and oversee specific projects as and when required.
16. To develop understanding and capacity related to equality and diversity within the organisations.

TERMS AND CONDITIONS OF SERVICE

- Hours of Work:** 37.5 hours per week with flexibility to work unsociable hours.
- Annual Leave:** As per Trust Policy.
- Superannuation:** The post is immediately superannuable.
- Health Screening:** The post is subject to satisfactory completion of pre-employment screening.
- General:** The postholder must, at all times, carry out his/her duties with due regard to the Trust's Equal Opportunities Policies.
- Terms and Conditions:** All Terms and Conditions are in accordance with new Trust Terms and Conditions of Service.

REHABILITATION OF OFFENDERS ACT 1974

Because of the nature of the work, this post is exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975. Applicants for posts are not entitled to withhold information about convictions which for other purposes are "spent" under the provisions of the Act and in the event of employment any failure to disclose such convictions could result in disciplinary action or dismissal by the Trust. Any information given will be completely confidential and will be considered only in relation to an applicant of a position to which the order applies.

DATA PROTECTION ACT 1984 AND CONFIDENTIALITY

All members of staff are bound by the requirements of the Data Protection Act 1984 and any breaches of the Act or of the confidential nature of the work of this post could lead to dismissal.

BRADFORD CITY PRIMARY CARE TRUST PERSON SPECIFICATION

REQUIREMENTS	ESSENTIAL	DESIRABLE	ASSESSED
<p>EDUCATION/QUALIFICATIONS TRAINING</p>	<ul style="list-style-type: none"> • Degree or equivalent • At least 3 years experience at a senior management level • Evidence of continued professional development over the past three years 	<ul style="list-style-type: none"> • Evidence of specialist education in equality and diversity • Master's Degree 	<p>Application Form</p>
<p>KNOWLEDGE/SKILLS/ABILITIES EXPERIENCE</p>	<ul style="list-style-type: none"> • Proven experience in the field of equality and diversity, with knowledge of the equal opportunities and diversity agenda's • Experience of working in health, social or voluntary sector • Knowledge of NHS workforce issues, particularly related to equality and diversity • Understanding of the current challenges facing the health and social services • A broad and in-depth understanding of cultural differences • Knowledge of Vital Connection; Equalities Framework for the NHS • Experience of working within a multi-faith, multi-cultural area & an understanding of these issues within the context of an inner city area • Experience of managing projects at a senior strategic level • Demonstrable experience of capacity to influence strategy across organisational boundaries • A broad understanding of health care and service issues related to equality and diversity • Evidence of ability to establish and maintain strong networks and links • Evidence of ability to facilitate policy development including undertaking research, analysing information and report writing. • Culturally aware and sensitive 	<ul style="list-style-type: none"> • Experience of NHS • Knowledge and understanding of the Health Improvement Programme and the Health Action Zone • Experience of community development work • Experience in use of Project Management Tools e.g. PRINCE 	<p>Application Form</p> <p>Interview Process</p>
<p>DISPOSITION</p>	<ul style="list-style-type: none"> • Able to manage time effectively • Confident presenter • Demonstrable diplomacy skills • Ability to work well under pressure 	<ul style="list-style-type: none"> • Mature awareness of politics 	<p>Application Form</p> <p>Interview Process</p>