Diversity Project

Diabetes and Maternity
Services

The Context

- **Population**
- **Patient centred services:**
  patient experience, standards, choice,health inequalities, codes of conduct
- **Legislation and statutory duties:**
  current and pending
- **Model Employer:**
  IWL, KSF, 10 point plan

1. **Population,** go to pop slides, brief summary

2. **Patient Centred Services – Patient experience** the stats demonstrate a widely diverse patient population. NHS provides T&C for everyone and nowhere does it say that a lesser quality of service should be provided to particular groups. **Patient perception** of the care they receive I.e. their reported experience is increasingly important as we move to a patient led NHS. This is reflected in many of the NHS standards that we are required to meet and will impact on whether patients want to choose us for their care as choice becomes a reality. The standards and professional codes of practice are tools to ensure that we meet the needs of all our patients. Ignoring the differences between people can result in perpetuating health inequalities rather than reducing them.

3. **The Legislation and Statutory duties** are and will continue to be strengthened to ensure that the needs of groups, historically disadvantaged by the various institutions of our society, are explicitly and demonstrably taken into account. Compliance with this legislation will be assessed as part of the NHS standards and by separate inspection by the DoH in conjunction with bodies such as the CRE. Not forgetting local performance management from the SHA, Scrutiny Board for Health and Social Care and Patient Forums
4. Maxine M to do employment

The Population

EM Approaching 87,210 (Total pop715,402)

- 32,000 Asian/Asian British
- 10,318 Black/Black British
- 3,447 Chinese
- 10,632 Mixed Race
- 2,528 Other ethnic group
- 19,210 White (Irish and Other)
- **Religion**
- 21,394 Muslim
- 8,267 Jewish
- 7,586 Sikh
- 4,183 Hindu
- 1,587 Buddhist

1. 8,500 Irish (white) and 10,632 “other white” may include e.g Eastern European
2. Asian includes mainly Pakistani (Kashmiri) Indian, Bangladeshi, “other”
3. Black includes Caribbean, African, “other”

These numbers will increase significantly when you consider the wider population of potential patients and employees
e.G Bradford has 75,188 Muslims and Kirklees 39,312

The Population

Disabled People (around 1/5)

- Over 128,000 long term health problem of disability
- 27, 500 people of working age economically inactive
- Approx 22,000 blind people
- Approx 1/7 Deaf/hard of hearing

Age

- There are 109,561 people over the age of 65
- NHS spends 40% of its budget on those over age 75
- Asian Women over age 65 have the highest rate of long term illness

Population

- 50% premature death from heart disease in South Asian population
- Higher incidence (6X)of Diabetes in Pakistani and Bangladeshi people, and Indian people (3X)
- Higher rates of smoking in BME men
- Prevelance of stroke for African-Caribbean and South Asian men 40% - 70% higher than general population
- Infant mortality higher when mother is born in Pakistan or in the Caribbean

These figures indicate that we can expect to see significant patients from different racial groups using our services
Impact of poverty and deprivation related to race (and disability and age). Clearly cannot operate a one size fits all.

Back to context slide to do patient centred services

Why A Model Employer?

- The NHS is the largest single employer of black and minority ethnic staff in England. In many areas it is the largest local employer – in competition with other employers for talent.
- Over the next ten years, half the growth in the population of working age will come from black and minority ethnic communities, as will 14% of all graduates.
- 30% of today's medical students are from BME groups. 60% of today's medical students are female

One of the pillars of the NHS Plan is that the NHS will become a model employer. I've taken these statistics from a presentation given recently by Surinder Sharma, the national director for Equality and Human Rights at the DoH.
Read through
If we are to recruit the best staff, especially against the backdrop of an ever-expanding private sector in healthcare, we need to appeal to a broad range of potential applicants.

Held to account

- **IWL**
  Workforce representative of local communities, feeling valued and supported, well-trained, inclusive management style
- **KSF**
  Minimum standard requirement, framework for training portfolio, pay gateways
- **10 Point Plan**
  Leadership by example, cross-cultural mentoring, Surinder Sharma

A lot of what we need to do is bound up in legislative requirements and legal proceedings are the ultimate sanction for poor performance in this area, but there is a growing trend towards mainstreaming diversity and equality activity and the performance management of it.

On the patient services side, there are specific requirements enshrined in the Standards for Better Health. Within employment the standards have also been set for us externally.
IWL – Within IWL one of the core elements is Equality and Diversity. Not only do we have to demonstrate that we take equality of opportunity seriously, but also that we value each employee as an individual – including them in decision making and making them feel safe and supported in the workplace.

KSF – Equality and Diversity is a core dimension rather than something optional as an add-on. It is a requirement for everyone to know their rights and responsibilities. It's a great move forward because it provides us with specific required elements that can be used as a template framework for a training portfolio when the new diversity trainer is appointed (insert news of appointment process). May result in a push from staff for training too as they will need to show competence to pass through the pay gateways.

10 Point Plan – Sir Nigel Crisp's 10 Point Plan was directed specifically at Trust boards. It required leadership by example, with specific objectives around diversity for all board members, and active engagement in cross-cultural mentoring. We were asked last year to declare our progress on it, and Surinder has given us the nod that more questions will be asked in the New Year.

Proving our commitment

- **Stats bear it out**

  Staff turnover rate amongst BME staff lower than white staff across the Trust:
  BME – 12.55%, White 13.48%

  Representative workforce:
  Leeds Census 2001 – BME 8.15%
  Trust – BME 10.09%

- **Case studies**

  Employability scheme, education liaison work, pilot information – stats still
  hold up within CMTs (eg 9.31% BME in O&G, 9.46% BME in Acute Med
  but need more qualitative data

So how do we prove as a Trust that we are meeting our obligations? We can provide statistical information that backs up our commitment to equality of opportunity.
Across the Trust as a whole, we have a workforce that reflects the ethnic mix of the local communities, with a higher percentage of BME staff than can be found in the local communities. It's interesting to note that there is a lower turnover rate of BME staff than white. This is the first time I've requested this analysis so it will be interesting to see if that is a sustained trend.

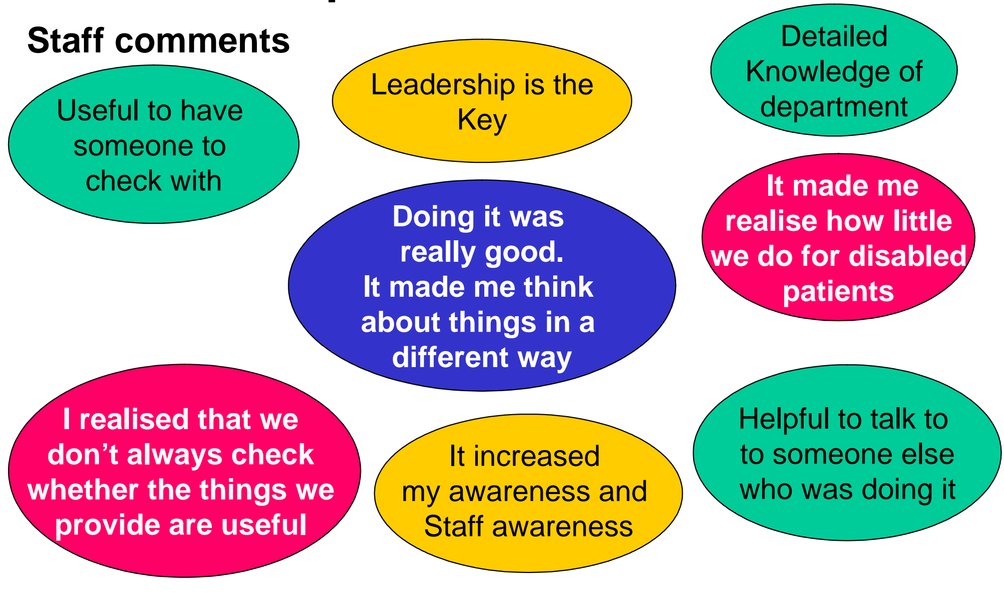
So those statistics and documentary evidence including policy and strategy statements and our Race Equality Scheme provide most of the quantitative data that we are required to produce. But that only tells half the story.

The richness of our data comes as well from case study evidence. We show our commitment to equality through our Employability programme, and the work of the Education Liaison department, working with adults and young people from the most deprived parts of Leeds – giving them information, advice, guidance and real opportunities to get into employment. The work we're doing with the pilot sites gives us further evidence of specific examples where we have made a difference to both staff and patients.

The Pilots

- Why Maternity and Diabetic Services?
- Test impact assessment process
- Create exemplar departments
- Make the case for Equality and Diversity

1. Significant Ethnic Minority population, staff willing to take part
2. Needed to pilot impact assessment and made sense to combine with pilots. Needed to know what our starting point was and to highlight good practice.
3. We used a prompt sheet of good practice to help staff to look at how they were delivering services.
4. We asked patients whether they felt that their needs were being met
5. We wanted to produce some evidence that would help to make the case for E&D across the Trust



1. The impact assessment tool was generally thought to be helpful. Staff found briefing, discussing with others doing the assessments, being able to check things out and having a good knowledge of the department and its procedures useful
2. (The section headed Human Resources tended to imply that this would be done by HR specialists. This was not intended and it has been changed in the roll out version.)
3. (For the roll out across the Trust a step by step guide was produced to make it easier to follow)
4. The check lists were helpful in focussing on the different issues and helped staff to think about their services in a different way.
5. We were particularly pleased that staff commented that doing the impact assessments made them think differently. We are trying to change the culture and changing the way people think is fundamental to the process.
6. It was generally a learning process for those involved
7. However leadership is essential to the success of the work as is good communication.
8. Staff commented that it was often the little things that made the difference.

Comments here from Denise, Maxine C, Helen etc

Exemplars of Best Practice

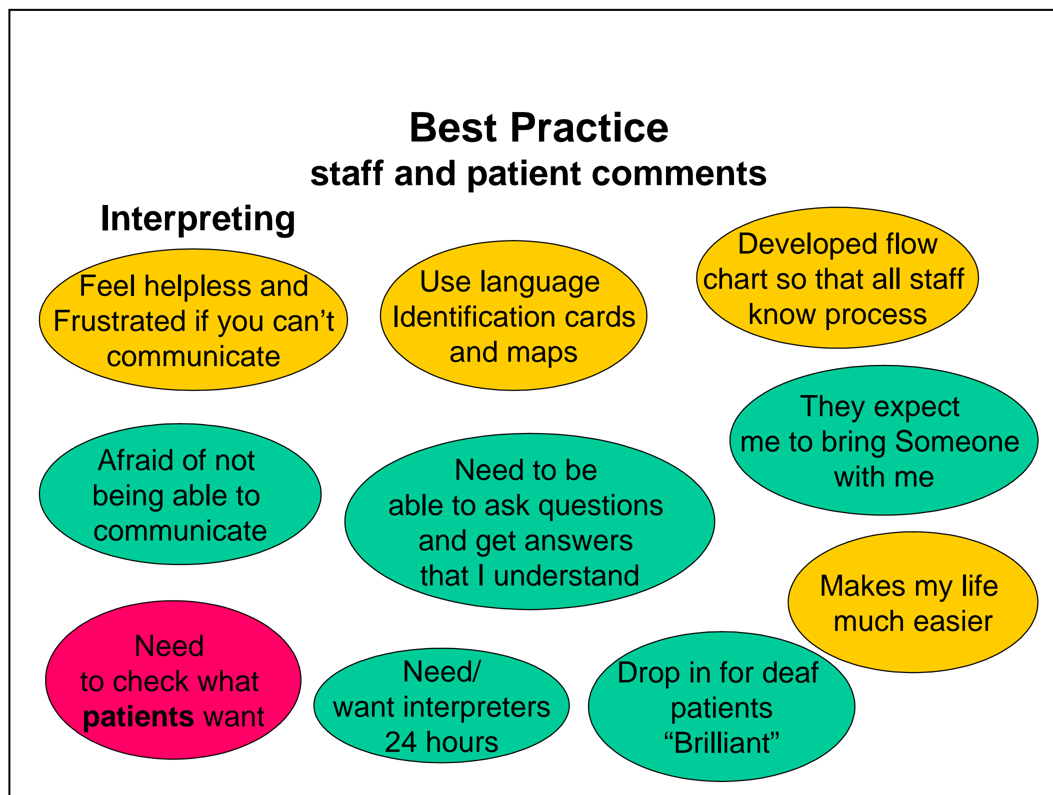
This is a process of continuous improvement

- Does the work undertaken add to the evidence that the Trust is benefiting patients and meeting best practice standards?

1. The the previous slide and the following slides show comments from patients and staff which demonstrate the benefits of proactively addressing equality and diversity.

2. In doing so we clearly not only better meet the needs of patients (helping us to meet the NHS standards and deliver more patient centred services) but we also provide a learning experience for staff which could ultimately lead to the culture change that is necessary to have a truly patient led NHS.

3. We can also begin to see the benefits of actively working to improve equality and diversity both in and for our workforce which will in any case be a necessity as the competition for staff becomes more intense and the proportion of BME graduates and people of working age increases.



1. This slide and the following slide relate to aspects of communication.
2. Effective communication between Healthcare professional and patient is fundamental to patient centred care and to a positive patient experience. Without it we are unable to meet just about every standard, guideline, professional code and statutory requirement let alone our moral and humanitarian obligations.
3. It is impossible to meet the requirements for a legally valid consent without effective communication
4. It is disrespectful to ignore patients communication needs
5. Even if staff believe that patients should speak English if they live here, the fact is that some of them do not and they still have a right to the same quality of service.
6. Rather justify why we should communicate effectively we should ask people to justify why they don't think its important.
7. More work needs to be done on use of family members as interpreters

Comments in this section from Helen, Maxine C, Denise etc.

Best Practice

Written Information

Tapes in 10 languages. Very positive feedback

English Subtitles on patient info screen in waiting area

Patient line TV subtitles on 2 channels

Translated leaflets are valued by patients e.g. Breastfeeding, Hearing test

Large print letters provided as standard

Other examples include

1. Emergency training now includes disability/language **(Maxine C)**
2. Religious needs e.g. fasting (dieticians), Adhan **(Denise)**
3. Work with PEAT to sign disabled toilets **(Helen)**
4. Improving colour contrast for visually impaired patients **(Helen)**
5. Tackling Health inequalities by special services for teenage mums, drug users **(Maxine C)**
6. Including diversity in bids **(Denise)**

Maxine C this is probably a good place for you to talk about the things you have noticed re examining eyes of new born babies, the use of "colour" in describing whether people are ill, differences in response to pane relief and your discussions with the anaesthetist.

Best Practice Employment

Improving Working Lives (Diabetes)

- Valuing staff
- Dignity and Respect
- Redeployment of disabled staff
- Flexible retirement
- Support for carers
- Religious observance (+ve benefits for ward management less than 1% sickness))

IWL (Denise)

1. Attention to Equality and Diversity in employment will contribute significantly to achieving practice plus as well as improving staff moral
2. Valuing staff e.g. including admin in team meetings

Dignity and Respect: staff confident to raise issues with managers. EM staff confident to raise Harassment issues and that they will be dealt with (Denise)

Redeployment of disabled staff presents its own problems. Lighter work means all redeployed within CMT needs to be dealt with on a trust wide basis (Denise)

Best Practice Employment

Improving Working Lives (Maternity)

- Zero tolerance
- Staff involvement in decision making
- Flexible working for carers
- Specific training re Sickle Cell and Thalassaemia
- Need for training re “colour” in illness

Maxine C

- Zero Tolerance, staff briefed, posters displayed, bullying and Harassment policy and officers highlighted to staff.
- Staff involvement in decision making, whole team meetings involving all staff

Patient comments

These comments are examples from both Diabetic and Maternity Services including African, Asian (Indian and Pakistani) Russian, Jamaican and White patients

1. There were very few negative comments. Two patients didn't like the African and Halal food.
2. One woman at clinic with her said that she always came to interpret for her mother. She supposed that some family members might not interpret properly and that there could be an advantage in using the interpreting service
3. Patients felt that information was given to them in ways that they could understand
4. They could ask any questions that they wanted.
5. Things were explained in ways that they understood
6. Where there were complaints ethnic minority patients complained about the same things that white patients complained about such as waiting times and car parking

It is apparent from patient comments that taking into account their individual needs makes a real difference to their experience of our services.

They feel valued and they are confident in the staff who treat them
Comments from Maxine C, Denise etc

Patient/Partner Comments

From Haamla Mums and Bumps Group

- **Very instructive and supportive**
- **A must for the pregnant wife**
- **I really appreciate the support,as my first baby died……**
- **I have learned about the help and facilities that are available here in the UK for pregnant women**
- **I received lots of information and it was very enjoyable**
- **Me and my wife are very grateful to each and everyone at Haamla**
- **The sessions are very beneficial to pregnant women especially if they have come from abroad**
- **Staff are very helpful and supportive**

1. **The Haamla Service** was originally established to provide advice and support to pregnant women of South Asian origin. It has recently been extended to include all Minority Ethnic Communities is Leeds including Asylum Seekers and Refugees
2. Staff work in the community, in GP surgeries and on the maternity wards to offer advice and support including breast feeding
3. Because the women feel secure within the Haamla service they often raise other issues including domestic violence, immigration, housing,welfare benefits, parenting skills and personal development. Haamla is able to signpost women to relevant agencies.
4. Teenage pregnancy support is also provided
5. This service, provided in partnership with sure start is an excellent example of work which promotes equality and challenges health inequalities.

Trust Benefits

Contributes to:

- Better patient focus/experience
- Achieving NHS Standards
- Achieving Practice plus IWL
- Recruitment and retention
- Information for Choice
- Staff awareness linked to action
- Compliance with ethical codes/codes of conduct
- Good reputation
- Compliance with legislation

1. **Better patient experience** improved patient satisfaction (should reduce complaints)
2. **Achieving NHS Standards** (necessary for Foundation Status)
3. **Practice plus** necessary for Foundation status
4. **R&R** People will want to choose to work for us leading to a more stable/satisfied workforce, reduced associated employment costs and an advantage in a competetive market
5. **Choice** Reputation can be influential in whether patients choose us
6. **Staff Awareness.** Raising awareness on its own is not enough. Staff can be aware and still not change anything but impact assessment work links awareness to actions which will lead to improvements
7. **Codes of conduct etc .** We would be ensuring that our staff complied with their codes of conduct etc
8. Through the work we can demonstrate to our patients and their families and to the various scrutiny and inspection bodies that we are taking action to ensure that we don't discriminate and that we are demonstrably committed to the promotion of equality. This will enhance our reputation and our compliance with the legislation.

What next?

- New E&D **policy** and action plan
- Board & senior manager training
- Directors/Heads of CMT accountable
- Improve leadership
- KSF Training
- Communication/making the case
- Impact Assessment/ethnic monitoring
- Ready for DoH/CRE assessment in Spring
- New HCC standard (Race Equality)

1. E&D policy and action plan will plug gaps and ensure levels of responsibility, accountability, management information and specific tasks
2. Board Training in process of planning
3. Objectives to ensure equality impact assessments (current and future) are done, actions followed up and E&D is included and given a degree of priority in performance management
4. Directors to be held accountable in the same way that they are for waiting times and finance.
5. Leadership is the key. Lead by example. Standing item on HQ board,Mentoring, performance management, 1-1
6. HQ Board to be responsible for satisfying itself that impact assessment have been completed for all policies etc submitted to it
7. Mandatory training to KSF level 2
8. Communicate via bulletin (regular slot), Quality Matters, lessons learned, via management structures
9. Research interpreting and family members and establish policy
10. Visiting policy that takes into account different cultural approaches
11. Disability Equality Scheme
12. Gender Equality scheme
13. Other work ongoing ethnic monitoring (collection and use)
14. Include ethnic group etc. in audit of clinical outcomes
15. The biggest challenge is leadership