Intercultural Opening and Young Migrants / BME¹ Youth: The case of the Health System in Scotland

Extended National Report

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Introduction

Overall Project Brief

The Moving Societies towards Integration project was designed as a scoping exercise to uncover potential good practices, criteria and indicators for ‘intercultural opening’ across 7 EU member states and across 7 different institutional sectors. This EU-Inti funded multi-partner project investigated activities leading to intercultural opening within host society institutions as a necessary aspect of integration as a ‘two-way process’ (Council of the European Union, 2004). The focus of the project was the procedures and practices that create intercultural opening towards young migrants in a selected sub-area in each partner country. The project partners analysed these to derive good practices and indicators of intercultural opening. The project focused on young migrants with “migrants” defined as third country nationals and their descendants and “young” defined as being 16-27 years old. The other project partners are: ACIDI, Lisbon; GERME/MITICES, Université Libre de Brussels; IPRS Psychoanalytic Institute for Social Research, Rome; Research Institute for Labour and Social Affairs, Prague; Finnish Youth Network, Helsinki; CJD Eutin, Germany (Coordinator).

The approach was deliberately ‘broad brush’ in order to uncover the maximum diversity of potential good practices. The timescale and resources of the project meant that a rich but limited amount of qualitative data could be generated. In Scotland, researchers at the David Hume Institute interviewed approximately 30 individuals from three main stakeholder groups: young migrants; public health practitioners within the National Health Service (NHS); and representatives of Black and Minority Ethnic (BME) and migrant organizations. Given the number of respondents, it must be borne in mind that this report and case study represent an informed snapshot of issues which merit further discussion rather than an exhaustive investigation into intercultural opening within Scotland’s health service.

Background to the Scottish Case

Immigration to the UK has been on the increase in recent years. The UK became a country of net positive immigration in 1994 with net immigration peaking at 237,000 in 2007. Migration inflows have also increased in diversity with immigrants coming from a wider variety of countries than was previously the case. The situation in Scotland has tended to mirror that of the rest of the UK. Scotland was traditionally a place of net emigration. However, levels of out-migration have fallen off since the mid-1960s, with net migration fluctuating around zero since the late 1980s. Since 2001 net migration to Scotland has been positive. With its smaller population Scotland saw a rise in migrant inflows to a peak of 27,000 in 2006/7.

According to the 2001 census, people born outside the British Isles made up 7.5 per cent of the UK population in 2001; in Scotland this figure was 3.3 per cent. While the proportion of people born abroad is much smaller in Scotland it has been increasing very quickly and in 2001 was up 34% from 2.5 per cent in 1991. Across Scotland, and the UK generally, migration from the Central and
Eastern European states that joined the EU in 2004 has made a significant impact with a sharp increase in migration from these countries to all parts of the UK. Unusually this has included migration to parts of the UK with little or no recent history of immigration, such as rural areas.

In the Scotland / UK context, there is no direct equivalent for what is described as ‘intercultural opening’ in Germany and other EU states. As a working definition, intercultural opening was understood as 1) the access/participation of migrants/ethnic minorities in an institution, and 2) awareness of migrant/ethnic minority cultures within an institution. To some extent it appears that the UK is on a rather opposite trajectory in terms of the integration of immigrant groups. While Germany, broadly speaking, is moving from a context in which a unitary identity of Germany is beginning to give way to a more pluralist, multicultural identity that acknowledges Germany as a nation of immigration, the current UK trajectory is the opposite and could be described as a move from the recognition of difference (multiculturalism) towards a greater emphasis on unity (community cohesion).

While at the UK level policy and political rhetoric around immigration have become more restrictive, this trend has been less evident in Scotland. To some degree this may simply reflect the fact that the Scottish Government is not responsible for immigration control and so is not faced with having to exclude or remove immigrants. However, a less stringent attitude is also visible in integration policy where more multiculturalist approaches continue to be pursued and access to resources is more generous. For example in contrast to England and Wales where integration funding for asylum seekers is available only after they have been granted status, in Scotland integration funds are accessible to asylum seekers from the point of arrival. There has been political effort to make Scotland welcoming to immigrants: for example the anti-racist ‘One Scotland Many Cultures’ campaign of the previous administration set about raising awareness of the positive benefits of the variety of communities in Scotland and aimed to tackle negative behaviour. This campaign coincided with the development of the ‘Fresh Talent’ policy in Scotland which actively sought to increase immigration to Scotland to counteract demographic decline and boost economic growth.

Alongside these changes in policy and politics came the developments in the race equality duties. The Race Relations (Amendment) Act 2000 built upon previous legislation. Its key features were to make the duty binding on all public bodies and to institute a positive duty to promote good relations. The Commission for Racial Equality was designated as the body responsible for enforcement of the legislation. One of its stipulations at the time the act came into law was that all public bodies have to draw up a publicly available document (known as a Race Equality Scheme) outlining how they are meeting requirements of the race equalities duties. This legislation began a process across the public sector of examining policies and practice to ensure they were compatible with the equalities duties. To some extent the equalities duties go against the trend away from multiculturalism and towards cohesion as these duties are chiefly concerned with ensuring the inclusion of different groups in mainstream planning and service delivery.

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3 The Race Relations (Amendment) Act 2000 came into effect in April 2002.
The equalities duties also form an integral part of Scotland’s policy and legal landscape as they are explicitly reserved in the Scotland Act 1998 that set up the Scottish Parliament. Furthermore the Scotland Act includes a broad definition of equal opportunities as the:

‘prevention, elimination or regulation of discrimination between persons on grounds of sex or marital status, on racial grounds, or on grounds of disability, age, sexual orientation, language or social origin, or of other personal attributes, including beliefs or opinions, such as religious beliefs or political opinions’\(^4\)

Consequently, the race equality duty is a key aspect of Scotland’s approach to the integration of minorities. The scope of the duties to eliminate discrimination and promote race equality in particular puts the burden firmly on public bodies to ensure they are open to Black and Minority Ethnic (BME) groups amongst others. In this sense the equalities framework fits well into a study looking at integration as a two-way process of mutual accommodation in which both institutions and migrants change to become more open.

**Why Did We Focus on the Race Equality Duty?**

The David Hume Institute took the UK’s National Strategy ‘Together in Diversity’, submitted for the European Year of Intercultural Dialogue 2008, as its starting point to identify the race equality duty as the focus in researching a UK/Scottish approach to intercultural opening. This document explicitly references the legislative framework of race relations legislation as setting the context in which intercultural dialogue takes place in the UK. This legislative framework is seen as exemplary of the UK’s approach to integration of ethnic minorities (and within this Third Country Nationals) and dates back to 1965 when the first Race Relations Act was passed.

As well as providing an exemplary aspect of the national approach to study, the Scottish experience with equalities duties is of immediate interest in an EU context as EU Anti Discrimination directives have required the implementation of similar anti-discrimination legislation across all Member States. Therefore we expect that the Scottish experience of the benefits and challenges of developing intercultural openness will have aspects that are easily transferable to other national contexts.

**Why Did We Focus on the Health Sector?**

The field of application of the equalities duties is very broad with the Race Relations (Amendment) Act 2000 extending the duty to apply to all public bodies. In selecting a sector in which to study the impact of the race equality duty we were guided by practical factors as well as seeking an area which we thought would yield pertinent findings. We wanted to conduct research in a sector not covered by other project partners and in a field that had not been extensively studied within

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\(^4\) Scotland Act 1998, Schedule 5, L.2
Scotland. We decided to focus on the health sector because there had been a significant policy drive to realize the race equalities duty within health from 2002 onwards, under the ‘Fair for All’ Strategy (see page 6 for further details). This strategy has seen the establishment of centralised bodies within the Scottish healthcare sector to improve organisational responses to meeting the needs of equality groups. The most recent body to be set up is the Equality, People and Performance Directorate (EPP) in April 2008, one of five directorates within NHS Health Scotland, the national public health agency tasked with improving the health of the population of Scotland. Investigating the impact of the equalities duties on how health care services are planned and delivered would provide interesting material. The key areas for consideration would be how this legal framework and the policies associated with it are advancing the task of ensuring that health services are open to young migrants in keeping with the concept of integration as a two-way process. This involves openness on the part of host community institutions as well as from migrants themselves.

A further justification for selecting the health sector is its potential to contribute to an integrated society. The role of the NHS in contributing to a more integrated and equitable society dates back to its founding principles – a universal health service for all based on clinical need rather than ability to pay, and free at the point of delivery. This orientation can be characterised as ‘equal treatment for equal need’. Furthermore, throughout the NHS’ 60 year history, staff of migrant and BME background have made an especially strong contribution to its development. The sheer scale of the NHS in Scotland, Scotland’s largest employer employing over 165,000 staff, means that if intercultural opening can be advanced within it, this can have a significant multiplier effect on the whole society. Indeed, many of the migrant/BME community representatives interviewed for this project said that achieving race equality in the health sector was important in achieving the same for society as a whole. They commented on the “huge potential” to use the race equality duty as a force for good. They saw this in terms of setting an example to the wider community by demonstrating an open welcoming attitude. One noted that as a major employer in Scotland the NHS could really make an impact if it achieved race equality within its institutions. Practitioners also noted that sometimes activities developed as part of meeting the race equality duty would have beneficial effects for the wider population.

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5 This body has recently seen its remit expand and this has led to a change of name. Before May of this year the Equality, People and Planning Directorate was known as the Equalities and Planning Directorate.
6 NHS Health Scotland is a Special Health Board within NHS Scotland.
7 One example of this is a series of NHS information leaflets developed for migrants in the Tayside area which are now being made available for the general population through Citizen’s Advice Bureaus.
Part 1 a) What is being done in the NHS in Scotland for Intercultural Opening?

The key area for investigation is whether the legal framework of the race equality duty and the policies associated with it are advancing the task of opening the Scottish health system to young migrants. To answer this question we firstly need to know what is being done to open up the health sector in intercultural terms. Background reading on the impact of the race equality duty in this and other sectors in Scotland highlighted the fact that while there has been much progress in terms of ‘process’ – guidelines and strategies for action – initiatives have not always resulted in changes on the ground in terms of outcomes for Migrant / BME communities (Audit Scotland, 2008; Black Leadership Network, 2008). In other instances, changes in practice have occurred at local levels, but these good practices have not been replicated at a national level. These findings were echoed in the appraisals of several respondents from Migrant / BME communities who were interviewed for this project.

This observation about the ‘process/practice gap’ informs the structure of the present section on what is being done. Firstly we will examine some of the key documentary material – action plans, strategy papers, guidelines etc. Following this we will present material from our interviews with practitioners, Migrant / BME community representatives, as well as younger migrants, who were asked for their opinions about outcomes for Migrant / BME communities. Finally, we will present the good practices which these respondents identified.

Process: Policy and Guidelines

A 1999 Scottish Executive policy document, ‘Our National Health’, included a commitment to: “ensure that NHS staff are professionally and culturally equipped to meet the distinctive needs of people and family groups from ethnic minority communities.” However, the drive to meet the healthcare needs of Black and Minority Ethnic (BME) and Migrant groups began in earnest in 2002, when the Race Relations (Amendment) Act came into effect. This was the catalyst for the publication of the ‘Fair for All’ strategy by the Scottish Executive that same year. The Fair For All report takes the form of a comprehensive ‘stocktake’ of existing policies and practice across the health sector in Scotland from which progress could be planned and which was intended to act as a catalyst for action in terms of energizing organizations in developing race equality policies. The main findings of the ‘stocktake’ were:

Health Boards and Trusts are at very different stages in responding to the health and service needs of ethnic minority communities.

The relative priority and salience of the issue has been low in some areas, and the main reason suggested for this by participants is the relatively low proportion of numbers of ethnic minority people and resource issues.
NHS managers and professionals would like support to build ethnic minority issues into mainstream organisational processes. This will also assist in addressing resource issues.

While some Boards and Trusts have undertaken some good project development work, many are at early stages of conceptualising and acting on ethnic minority health issues and concerns.

The ‘stocktake’ has acted as a catalyst for a wide range of NHS organisations to begin thinking about how they address ethnic minority health needs.

There are individual examples of good practice and these can be usefully drawn upon by the NHS in Scotland more widely in developing models of good practice that are systematic.

The service needs a strategy for progressing on a number of fronts, rather than addressing ethnic minority health problems through one-off projects.

In rural areas a ‘colour blind’ approach to ethnicity and culture may result in services that fail to reach ethnic minority people or meet their needs.

Fair For All (2002:5)

The report went on to make a series of recommendations which included: the need for a strategic approach; establishing clear ownership, accountability and responsibility for race equality issues; establishing the better assessment of health needs and translating that knowledge into action; filling gaps in service provision and establishing partnerships working with ethnic minority communities; developing race equalities and equal opportunities polices and integrating these into human resources policies; removing barriers to access; recruiting ethnic minority staff and developing better development and retention of ethnic minority staff; developing better dialogue with ethnic communities and developing the capacity of the ethnic minority voluntary sector to that end.

In summary, the race equality duty and subsequently the Fair for All strategy were crucial in kick-starting a more systematic engagement with race equality issues in the NHS in Scotland. Fair for All not only signalled a recognition by government of the problem of discrimination against ethnic minorities in the Scottish health service but also formed the basis of a strategic policy for intercultural opening. In these respects, the Scottish approach to intercultural opening in the health sector is recognised as being more pro-active and progressive than in other EU states (Bhopal, 2007: Lorant and Bhopal, 2010).

Importantly, this policy has been supported by an intermediary contact body with policy refinement and support functions to help all branches of the NHS live up to their race equality duties. Initially, this body emerged from single-strand equality work on race, in the form of the National Resource Centre for Ethnic Minority Health (NRCEMH), set up in 2002. Short term funding existed for this body for several years, but in 2008 its role in promoting race equality was secured when it was merged with bodies working on other equality strands to create NHS Health
Scotland’s Equalities and Planning Directorate (now the Equality, People and Performance Directorate (EPP). The EPP is the subject of the case study in section 1.b. The main advantage of bringing the single equality strands together is that race equality is no longer an isolated issue. It is now firmly embedded in the broader equalities structures of NHS Scotland, making it much harder to sweep away (Lorant and Bhopal, 2010).

Translating the strategic policy on race equality into every-day outcomes on the ground requires more than the creation of the EPP however. Two principal means are identified by academics very familiar with race equality in the Scottish healthcare sector: (i) equality impact assessment and (ii) a toolkit for use by health boards known as ‘Checking for Change’\(^8\) (Lorant and Bhopal, 2010). This toolkit was published and piloted with health boards and it was possible during this piloting work to demonstrate progress to meet specific criteria in the toolkit. The expectation is that Checking for Change will continue to serve as a reference in the new performance assessment landscape, although the emphasis is shifting from the ‘static’ linear criteria found in Checking for Change to a set of criteria oriented towards continuous improvement.

There are 5 core progress areas derived from the Fair for All guidance: energising the organisation (steering and management commitment); demographic profile (better research about ethnic minority populations living in each health board area); access and service delivery (better access and better services, including services adapted to BME communities needs); human resources (recruitment of BME staff); and community development (better partnership with BME communities in decision-making). The table below gives examples of what is done to achieve progress in each area.

<table>
<thead>
<tr>
<th>Progress Area</th>
<th>Examples of what is done to achieve this</th>
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<tbody>
<tr>
<td>Energising the organisation</td>
<td>- development of an up-to-date Race Equality Scheme (a legal duty)</td>
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<td></td>
<td>- training in equality impact assessments, and monitoring of training completion (numbers, %, by grade, specialism, location)</td>
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<tr>
<td></td>
<td>- leadership from senior management – equality ‘champions’ at board level</td>
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<tr>
<td></td>
<td>- recognition and rewarding of good practice</td>
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<tr>
<td>Demographic profile</td>
<td>- surveys of local BME populations and their needs</td>
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<tr>
<td></td>
<td>- forecasting local demographic trend</td>
</tr>
<tr>
<td>Access and service delivery</td>
<td>- equality impact assessments of policies and services (a legal duty)</td>
</tr>
<tr>
<td></td>
<td>- monitoring of service use by BME groups (linked to census data)</td>
</tr>
<tr>
<td></td>
<td>- training of frontline staff to respond to BME patients’ needs, and monitoring of training completion (numbers, %, by grade, specialism, location)</td>
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\(^{8}\) ‘Checking for Change’ (NRCEMH, 2005). It should be noted that this toolkit is no longer in day-to-day use in NHS Scotland.
interpreting services at hospitals and GP surgeries [family doctor]
- link workers at the Minority Ethnic Health Inclusion Project (MEHIP) to advise BME patients about the services available and help them to navigate the system.

| Human resources                      | - monitoring of job applicants and staff (current staff, promotions, leavers, those involved in grievances and disciplinary action) by ethnic origin (a legal duty)
|                                      | - training in equality and diversity (a legal duty) |

| Community development               | - creation of BME consultation forums
|                                      | - monitoring of procurement and supplier diversity |

Equality impact assessment is the second means identified to translate policy into practice. This is a legal duty under the Race Relations (Amendment) Act 2000. The aim of equality impact assessment is to vet any proposed action or policy in terms of potentially disproportionate adverse outcomes for different equality groups, including ethnic minorities. If disproportionate outcomes are identified, an explicit plan of action must be drawn up to correct them.

The proliferation of policies, guidelines, toolkits and monitoring procedures as summarised above is indicative of the recognition of the problem of race inequality in the Scottish health sector by government and senior NHS management. The strategy proposed to deal with these inequalities, underpinned by the legal framework on equal opportunities, has been recognised as an example of good practice in the European context (Lorant and Bhopal, 2010). The question which remains however is the extent to which these policy processes have been translated into good practice and improved outcomes on the ground.

Translating Processes into Practices: a View from the Grassroots
The material presented in this section derives from two focus groups and approximately 10 interviews. One focus group comprised young migrants; the second focus group consisted of public health practitioners. Those interviewed were mostly representatives of Migrant / BME organisations, but also included others outside the third sector with experience of health service provision, research, policy engagement or a combination of the three (for details about methodology please consult Appendix 4).

Several Migrant / BME representatives recognised the amount of work which has been put into race equality and health since the Race Relations (Amendment) Act 2000 came into effect. One respondent noted that “in health boards, we are aware that everyone has a race equality scheme, or a single equality scheme, that people are impact assessing, that it’s on agendas now, in a way that it probably wasn’t a decade ago.” Nonetheless, some respondents wondered whether certain
staff really understood why these matters are important. They commented that while progress is being made in terms of intercultural opening, too much of it is oriented to processes and not enough is perceptible in terms of service delivery to users on the ground.

“Scotland is way ahead in terms of Fair for All guidance and targets, and having a 30 strong health directorate is a great resource, but for people on the ground the little things just are taking such a long time. (...) It’s not about saying there hasn’t been any progress, but so much of it is process” (BME /Migrant representative).

Respondents from the focus group with public health practitioners were positive about the impact that the Race Relations (Amendment) Act 2000 had had. The practitioner’s focus group noted that the laws strengthened their work. There was a sense that there remained a lot still to be done and that there were communities still to be reached but the impression was that the framework the equalities duty provided made it easier to map out ‘who is missing?’, as well as what needed to be provided for different communities. However legislation in itself was not sufficient. One interviewee called it a ‘first step’, another said that it established a ‘baseline’ for more systematic intercultural opening. The legislation was seen as an important catalyst to action with all convinced that less action would be taken if a legal duty did not exist.

Perhaps most telling is that the young migrants themselves had little knowledge of their legal entitlements and protections. There was little direct knowledge of the race equality duty although participants had a generalised sense that discrimination was not allowed. As such this group were not able to comment on how intercultural opening had progressed in the health field. However there was much talk about the variability of services and the lack of any discernable pattern. Some commented that if a GP practice or other service was known to provide a good service which was appropriate for a particular ethnic group this frequently became common knowledge in a community.

“You hear so many different accounts of the NHS service. It seems like you find one nice person and then everybody hordes towards them...because there is no uniform service...so it really depends on the person” (Response in young migrant’s focus group).

Young migrants in the focus group were unsure of how they might go about complaining of discrimination or even how they would identify discrimination or poor service. This may suggest that much of the advances in the race equality duty have not really impacted on popular consciousness. Perhaps greater awareness of the duties would be beneficial in helping BME and migrant communities in using the protections that exist to greater effect. On the other hand, the young migrants reasoned that if they were faced with a situation in which they felt discriminated against or that service provision disadvantaged them due to particular needs, they would be able to look up what the avenues for complaint were. However, although some of them described incidents when they or a family member had been treated poorly due to cultural or language difficulties they made no mention of having sought to address these difficulties with healthcare service providers using the protections available to them. Some in the focus group thought having knowledge of entitlements would be helpful.
While Migrant/BME representatives were positive overall in their judgements about the legislative framework, they were more cautious than the practitioners in their praise of the race equality duty and occasionally critical of what had been achieved with it so far. That said, nobody advocated ripping up the legislation. As one person said, “I wouldn’t want to be without it [the race equality duty].”

As regards ethnic data and monitoring, which is one of the most crucial elements for improving the health and healthcare of ethnic minorities (Bhopal 2007), the legislation has been indispensable. As one Migrant / BME representative commented, “ethnic monitoring comes under legislation, so there’s a legal requirement to do it, which is powerful.” Nonetheless, research has shown that ethnicity data has been patchy (Lorant and Bhopal, 2010) and there was an indication in our interviews that while the collection of ethnicity data and reporting has been going on for some time, the full extent of the challenge of collecting ethnicity data has only recently been appreciated. However, support is now in place to meet this challenge and recent ethnicity data from hospitals made public on the website of the Information Services Division (part of NHS National Services Scotland) shows progress. Equality impact assessment has also been in place for some time now, but this is one example of promising initiatives not being fully translated into practice according to one Migrant / BME representative. "There's huge potential but it's very badly done at the minute here, so it's not leading to the changes we'd hoped for."

Respondents also perceived that management strata have manifested greater commitment to intercultural issues since Fair for All, although this could not be said of all managers at all levels in the NHS. Greater commitment was exemplified, according to one respondent, in the networking activities that NHS personnel are involved in through attendance at various equalities forums which bring together third sector representatives and practitioners. Despite the commitment from management to act on race equality, others questioned whether participation of BME communities took place on an equal footing:

“There are responses. There are lots and lots of meetings and subcommittees and this and that about community relations and good relations, multicultural society, diverse working and social cohesion.(...) And yet, in so many things in Scotland - and I don't know about England - it still comes from a point of view of power. We know that we should be doing these things, so we are instigating these committees and these investigations. Yes we will involve you up to a certain point, and that's about it. Yes you're around the table discussing: are we really listening? I'm not sure. I don't think there's much listening going on.” (Migrant / BME representative).

**Good Practices**

Nonetheless, the same respondent gave the example of a very positive experience in her view which could serve as a model of good practice in breaking down these participation barriers. This experience arose out of a project to help health boards design their Equality Schemes, piloted in conjunction with the Black Leadership Network. This model led to “a lot of buzz, a lot of excitement, and people felt a lot more motivated, energised and confident that they weren't going
to be hit behind the head with "you're racist": no, it's about working together and moving forward. So that was really really good practice, and I say that from my point of view but some of the boards say that too" (Migrant / BME representative).

In addition to this model of engagement with BME communities, as well as the legislative framework for equal opportunities mentioned above, one further example of good practice was felt to be the establishment of NHS Health Scotland’s Equality, People and Performance Directorate itself. As one respondent said, in reference to the EPP:

“The Equality Directorate is a huge resource, to have that number of staff supporting health boards is very valuable. I haven't heard of that kind of resource going into any other regions, so that's clearly something which has been done practically on the ground” (Migrant / BME representative).

Such positive comments as these led us to look more closely at the EPP as an example of best practice. This is the focus of the case study in the next section.
NHS Health Scotland’s Equality, People and Performance Directorate (EPP) originated in April 2008 to provide: “a centre of expert advice and support to NHS Scotland on delivering equality and diversity, eliminating discrimination and reducing health inequalities.” The Directorate is one of five directorates within NHS Health Scotland, the national agency tasked with improving the overall health of the population of Scotland. The EPP has about 30 members of staff divided into three teams: the Equalities Support Team, the Equalities Development Team, and the Planning and Performance Team. The Directorate seeks to work in partnership with NHS boards and other stakeholders to help deliver better health outcomes for all communities and individuals and to help health services show they are improving health outcomes. While the Directorate is clearly a key institution working towards the implementation of the equalities duties across the board, it should be noted that the Directorate has no formal monitoring role or enforcement powers – these lie with NHS Quality Improvement Scotland, the Scottish Government, and the Equalities and Human Rights Commission, with each Health Board being accountable to the Scottish Government. The core component of the Directorate’s mission is to provide expertise and advice to help health boards and other bodies not only to comply with the Race Equality Duty but also to better understand BME groups’ needs on the ground, thereby improving services. The Directorate seeks to do this by acting as an exemplar, demonstrating how the equalities duties can be mainstreamed and acting as a catalyst and supporter of change.

The Case Study: Framework and Methods

This case study of the Equality, People and Performance Directorate (EPP) was mainly based on documents supplied by the EPP or available on the EPP website. This was supplemented with short, targeted interviews with three EPP staff. EPP staff were selected by identifying those whose roles and expertise related to aspects of the race equality duty. However, it was not possible within the timeframe of the project to interview all relevant staff and those we interviewed often did not have direct responsibility for the aspects of race equality they were questioned on. Given the limited time and scope of this case study it must be borne in mind at all times that this study is a snapshot of the EPP rather than an exhaustive study. As a snapshot it provides interesting glimpses of issues worthy of more investigation rather than hard and fast findings of the state of the EPP or of the race equality duty within Scotland’s health service. However, it does provide an interesting example of how one organization is working to promote good practice on race equality in the health sector.

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9 The Planning and Performance team has a purely corporate role internal to NHS Health Scotland and is not directly involved in promoting intercultural opening.

To provide a structure for the case study, Hubertus Schröer’s ‘quality criteria for a successful process of intercultural opening’ were used to provide a framework for evaluation. A translation of these criteria can be found in appendix 3. Many of the questions Schröer poses as criteria for a successful process of intercultural opening would benefit from more detailed exploration both on the documents and in terms of what happens in practice. The short timescale of this project phase and the need to write a short report have limited the depth of investigation and have yielded ‘broad brush’ responses to large and complex issues. However the case study does provide a helpful glimpse of the comprehensive manner in which a legislative framework for race equality provides a baseline or framework within which work towards intercultural opening can then take place more systematically.

**Intercultural Orientation of the Organisation**

**i) Is there a leading concept in the organisation which mentions intercultural orientation?**

Although the terms ‘intercultural openness’ or ‘intercultural orientation’ are not used in the British/Scottish context there is much within race equality and diversity policies that has similar meaning or objective. Consequently we were looking for measures that aimed to open up the organisation to migrants or sought to ensure the inclusion of migrants. Within this project we were particularly focused on the ways in which state or host society institutions actively sought to open themselves up to migrants, as opposed to measures that were neutral and left it to migrants to include themselves. The former orientation illuminates intercultural opening as a ‘two-way’ process where both migrants and state institutions change in response to each other.

The Mission Statement of the EPP states that its vision is of “a person-centred NHS that eliminates discrimination, embraces diversity and is fair for all, and where all people experience equality of opportunity and equity of treatment.” Arguably only the phrase ‘embraces diversity’ provides definite indication of having to work proactively to include migrants. However, in outlining how the EPP envisages its contribution and work it becomes clear that many of its actions are intended to work proactively on state institutions encouraging change and working practices that are intended to facilitate the inclusion of migrants as part of Black and Minority Ethnic (BME) groups. For instance, there is mention of ‘mainstreaming’ equalities into the day to day work of the NHS. Mainstreaming implies change within state institutions to make it easier for migrants (among other groups) to take part as both service users and service deliverers. Through the incorporation of mainstreaming into its agenda, the EPP demonstrates commitment to the idea that state institutions need to change and develop in order to deliver on the equalities duties. This is demonstrated further when examining operational goals and measures and initiatives in the sections below.
**ii) Are there operational goals to achieve this?**

The EPP’s 2008/9 Work Plan divides objectives into three categories: (a) External Change and Delivery, (b) Organisational Change and Delivery and (c) How We Work, Engage and Share. This reflects the different aspects of the EPP’s role. In part it is concerned with promoting equalities externally across other parts of the health service. At the same time it is concerned to operate internally in a way that promotes and demonstrates equalities. Finally there is a need to bring the external and internal dimensions of the work together looking at the networks and partnerships that help bring this about.

Within the 2008/9 Work Plan there are numerous objectives that aim to ensure the intercultural orientation of the organisation and of the health service more widely. For instance under objective 1.11 there is a commitment to work on understanding HEAT targets\(^{11}\) in terms of equality issues and to work with Scottish Government on developments that embed equalities indicators in the national HEAT targets. Thus the EPP’s work here involves trying to adapt key mainstream targets to make them more interculturally open. One interviewee described the EPP’s focus as trying to break down race equality and diversity into simple and straightforward terms so that mainstream staff felt able to engage with them, thereby allowing these issues to be better mainstreamed.

**iii) Are there measures and initiatives?**

Some of the measures and initiatives at the EPP fall directly within the race equality strand. For instance objective 1.2 of the 2008/9 Work Plan describes a project to improve mental health outcomes in three selected health boards that focuses on minority ethnic populations. The Race Equality and Mental Health project outlines an in-depth programme of research, consultation and policy and service delivery development to be trialled in three health boards. Aspects of this project focus on the specific problems BME groups may have in accessing mental health services and specific limitations mental health services may have in terms of their appropriateness for people who are culturally or linguistically different. In trying to develop services that are more open and appropriate the project is an example of the EPP working to make the health sector more interculturally open.

\(^{11}\) For more information on the HEAT performance measures agreed between the Scottish Government and health boards see: http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273
Structures of Sustainability

i) **Is managing diversity/intercultural opening understood as a top-down management task?**

In the 2008/9 Work Plan there is explicit mention of developing the ability of the directorate and senior colleagues in NHS Health Scotland to provide leadership on the equalities and diversity agenda. This has been made a regular agenda item of board meetings. The EPP staff interviewed felt they were not in the best position to comment on the priority equalities objectives received alongside other health policy objectives as they did not work directly with health boards. It would have been interesting to interview EPP staff who had outward facing roles on this point.

ii) **Is there an organisational unit/contact person to support this?**

Given the EPP exists to promote equality and diversity in the health sector it is arguable that supporting intercultural opening (understood as promoting the race equality duty) is a function of the EPP as a whole. In addition the EPP co-ordinates a network of ‘contact points’ across the different health boards: their role is to lead on equalities and diversity within the different health boards. The Business Plan includes an Equality Managers Programme that seeks to build these relationships by supporting communication between the contact points and assisting them in their role by signposting them to relevant information and developing an infrastructure of support. The Work Plan also includes objectives that aim to improve access to the EPP’s resources for external partners such as websites and newsletters (e.g.: objectives 3.3 & 3.4).

The EPP works across all equality strands. It is therefore difficult to tell what priority race equality receives in relation to other equalities. Community representatives were concerned that race equality would be eclipsed by other equality strands. The way the EPP is structured makes it difficult to ascertain whether any equality strand is prioritised. The EPP staff who liaise with specific health boards do so across all strands, so the external work is divided by health board rather than by equality strand. In interviews EPP staff commented that efforts were made to give equal priority to the all the equalities strands, but there was no formula by which the EPP sought to ensure this. Within the business plan there is an indication of the desire to treat all strands equally in the commitment to undertake one project on each of the specific equality strands.

iii) **Is this structure supported by sufficient staff and financial resources?**

It is a difficult judgement to determine what constitutes ‘sufficient resources’. This was not a question we could properly investigate within the scope of this case study. Certainly all three interviewees felt their work was adequately resourced. One key question emerging from the interviews with community representatives was concern about a shortage of resources in the future given the tougher economic climate. None of the three interviewees knew of cuts to equalities budgets in the immediate future and staffing levels were set to continue unchanged. In
addition one interviewee reported that where cuts had to be made in health budgets these would be equality impact assessed to ensure no equalities group experienced a disproportionate impact from cuts in services. The interview feedback would be reassuring to community representatives who when interviewed were concerned that shrinking budgets would mean that equalities work would fall by the wayside.

iv) Are there network structures which allow bottom up participation?

The EPP work and business plans include a number of objectives to allow for bottom up participation or building better networks and partnerships. Establishing effective working relationships with NHS boards is included in objective 3.5. The Business Plan notes that many of the EPP’s projects are designed in consultation with the network of equality and diversity contacts across the NHS. In terms of engaging with service users objective 3.6 is to develop a strategy for community engagement. One interviewee spoke of more resources being made available to engage with the voluntary sector and that there was a push towards trying to improve community engagement.

v) Is the process of intercultural opening understood as a mainstreaming strategy?

As noted above much of the work of the EPP concerns itself with trying to mainstream the equality and diversity agenda.

Qualification of Staff

i) Are there measures for intercultural sensitisation and qualification of staff?

Objective 1.7 in the Work Plan deals with workforce development. The EPP sets out to advise health boards and others regarding workforce learning and development on equality and diversity as part of its role. Again this is approached by mainstreaming equalities with one of the work plan goals being to include a module on equality and diversity in the Knowledge and Skills Framework which is a UK-wide NHS competency framework. Other work plan objectives also touch upon developing staff competencies; for instance, developing expertise in carrying out Equality Impact Assessments, (2.7). The Business Plan also includes elements that contribute to the intercultural sensitisation of staff. The Capacity Building Programme for Boards includes several meetings and other working groups that aim to build up capacity in the health boards and encourage understanding and ownership of equality and diversity issues within the health boards.

ii) Are there measures for targeted gaining of staff to represent diversity?

Workforce monitoring is evident from Annual Reports. The Annual Report is made public and is discussed at board meetings within NHS Health Scotland. From the interviews we learnt that human resources policies are in place and include equality and diversity. These are due to be
reviewed in view of new guidelines expected from the Scottish Government. In addition there are plans to set up an equality and diversity forum for staff to allow them to feedback and discuss the inside perspective of working in the sector.

The EPP’s work on benchmarking with health boards includes a section investigating how well work force monitoring is undertaken and whether action is taken to address situations when particular groups are underrepresented at various levels. Responses from health boards show that it is only in some boards that under-representation is acknowledged and acted upon.

Clients

  i)  *Are needs of clients known (through surveys etc)?*

The EPP is working towards improving data collection regarding equality groups. Within the work plan this is reflected in objective 1.6. The EPP is also working to improve awareness within health boards about the need for better patient monitoring and sets out to work with others to influence the mainstreaming of equality related demographics in targets (objective 1.9.) Specific projects such as the Race Equality and Mental Health project also address the need for improved data. One interviewee explained that while the EPP cannot force health boards to collect data, the EPP works to support health boards in understanding how to collect data and disaggregate it in a meaningful ways that allows the discrimination faced by particular groups to become visible. This was described as a learning process that the EPP tried to initiate and support.

  ii)  *Are access hurdles and inhibitions identified and addressed?*

The Translation, Interpreting and Communications Support project provides one example of an initiative designed to overcome access hurdles by improving access to own language materials and interpreters. One interviewee acknowledged that it was perhaps still too early in the EPP’s existence to have completed the feedback cycle to the point at which improved data could feedback into actual change. There was a lot that still needed to happen. However monitoring for the accessible communications project meant that there was a clearer idea of what types of own language materials and support were being requested and these could then be supplied in a more tailored way – responding to changes in the demographic profile.

*Culture-Sensitive Evaluation*

  i)  *Are the goals operational? Are there indicators to check achievement of aims?*

From the documents it appears that operational goals have been set. There are definite outcomes and outputs set and a system of monitoring is envisaged to check whether goals have been met.
ii) **Do these indicators take into account the special circumstances of multi-ethnic staff and clients?**

Within the work plan it is possible to identify projects where indicators are being developed and implemented especially to pick up on issues that may impact differentially on different ethnic groups. For instance the race equality and mental health project includes phases of designing specific indicators.

iii) **Is there institutionalised reporting and monitoring?**

There is a clear indication that reporting and monitoring structures are becoming institutionalised. Objective 1.4 of the work plan sets out the intention to conduct and build on a national benchmarking exercise. This shows that not only is data being collected and outcomes are being monitored but that there is the attempt to create a national rationalised system for doing this that allows for comparisons to be made across health boards and eventually over time.

In addition the EPP’s work plan sets out to support partners with patient monitoring. This includes both raising awareness of the need for equalities related monitoring and efforts to mainstream equality related demographics.

### Concluding Remarks

Checking the EPP’s work against the range of Schröer’s quality criteria for a successful process of intercultural opening we find many positive initiatives and responses indicating that successful intercultural opening is taking place. The efforts to mainstream equality work into general targets and skill sets indicates that the mainstream health service is being supported to adopt practices that make it more accessible and more appropriate for other groups. There is a lot of work being done and conducting the case study illustrated the wide remit of issues and practices that are involved in the process of intercultural opening (data collection and monitoring, service planning, workforce diversity, etc).

This brief review of the documents is not able to assess how successful the EPP is in effecting change on the ground but it does show the EPP working right across the spectrum of relevant issues. The race equality duty gives a body like the EPP a legal framework around which to organise its work and promote institutional change on race equality in what has traditionally been a compliance-orientated organisation. Although the EPP has no enforcement powers the legislation gives other stakeholders a vested interest in the expertise and advice that the EPP is developing, enabling them to fulfil their legislative duties on race equality. What is perhaps most significant however is the opportunity structure that the legal framework represents for those
working in the EPP. From this strong legal position, the EPP seeks to promote diversity and equality and facilitate organisational change in the NHS in Scotland beyond mere compliance. The EPP works in a variety of ways to develop best practice and improve progress towards race equality across the health service in Scotland.
Part 2) What is Particularly Important to Open up the Health System in Scotland in Intercultural Terms? What Criteria are Particularly Relevant?

While the past decade has witnessed significant progress via the creation of dedicated agencies and significant policy and legislative change, the indications from recent literature and the initial fieldwork presented above imply that there is still some distance left to go as regards race equality and intercultural opening (Audit Scotland, 2008; Black Leadership Network, 2008). The fieldwork documented in the next section of this report provides a glimpse of how efforts towards intercultural opening are perceived by three groups of stakeholders: practitioners trying to deliver race equality within health boards and other parts of the Scottish healthcare sector; representatives of migrant and BME community organisations; and young migrants themselves. It should be borne in mind that these perceptions are not a judgement on the specific work of the EPP; rather the focus is broader, addressing the healthcare sector in Scotland and elsewhere when appropriate. Respondents were asked what is particularly important to open up the health system interculturally (the focus of the present section), as well as what the barriers to this process are (the focus of Part 3).

When shown the Moving Societies criteria developed by the project partners over the course of the project (see Appendix 2), most respondents agreed that taken as a group they were useful and exhibited strong awareness of the principal issues confronting practitioners in the field of intercultural opening and equalities.

One respondent felt that the existing criteria in Scotland which have been developed since Fair for All are as strong as – if not stronger than – the Moving Societies criteria. While most individual criteria were seen as relevant, five sets of criteria were singled out as being particularly relevant for intercultural opening in the NHS in Scotland. These were: commitment from the management (slide 4); a diverse workforce (slide 1); participation of the target group (slide 8); intercultural services (slide 6); and research (slide 9). In addition, respondents suggested one or two items which they felt were indispensable to intercultural opening which did not feature on the Moving Societies list, namely human rights, equality impact assessments, and an anti-discrimination perspective. These will be discussed at the end of this section.

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12 For details of the participant engagement process and the methodology employed in parts 2 and 3, please consult the appendices to the extended national report.
13 In addition to their knowledge of the Scottish context, some respondents also had experience of additional countries, such as New Zealand, the United States, and Ireland
14 See Appendix 2 for details of each slide.
Commitment from the Management

As regards commitment and leadership from management on equality issues, the view from Migrant / BME community representatives and practitioners within the NHS was largely positive. One Migrant representative noted that “there is a lot of will around the place to work, so there are pockets of people who want to make things work, and are struggling to find ways, so when you get like minds in the same room sometimes there is the potential for miracles.”

One body which was felt by many to encapsulate this will to make things work is the EPP. Another example indicative of progress here is the Mutuality, Equality and Human Rights Board (MEHRB), based in the Health Directorate of the Scottish Government. MEHRB’s role is to provide an internal accountability mechanism to monitor what is happening in boards around equality and diversity. In one Migrant / BME representative’s opinion, “it gives that internal top-down message that this is something we’ve got our eye on and we want you to also have your eye on as the Chief Executive [of a health board].”

A local activist in Glasgow agreed that there was commitment, backed up with resources, from within the management levels of the NHS to promote intercultural opening. Her one concern was that this commitment did not cascade down to the grassroots:

“there is as far as the NHS is concerned a clearly stated commitment from the management to implement intercultural opening at every level. I think the will is there, and I think there is an appetite for equalities, and from what I see they pay a tremendous amount of money in terms of equalities, they really do, they send lots of people [on training], but it’s always at quite senior levels, and there’s no trickle down.”

Workforce

Commitment from management is important, but so too is BME representation at senior management levels. One respondent argued strongly that having representation within institutions, particularly at leadership levels, is probably the most important aspect of intercultural opening. “Just by being there they are sending quite a strong signal in raising the profile of that group but they also have a really important function in terms of mentoring, and I think a really important role in terms of key education.” Similarly, Migrant / BME representatives spoke of how having a workforce that is ethnically diverse would help to transform the culture of the workplace and be valuable in delivering culturally sensitive services as well as delivering mainstream services.

“It is important for the workforce to reflect diversity, but not on a percentage basis...that’s a red herring. I think the workforce has to be more diverse. People get into the mindset of thinking BME staff work with BME patients, actually BME staff work with everybody, their added value is that they can work with BME communities more appropriately. I think it is very important that services are reflective” (Migrant/BME community representative).

Having a diverse workforce seemed to mean more to migrant representatives than having an ethnic mix in the workplace that exactly reflected the community at large in percentage terms.
The interviewees spoke of openness creating an atmosphere where difference was valued and that having this environment would also make service users feel more included.

"I think it’s important to have a diverse workforce...it enables more access to different experiences and those people of difference can share, if a workplace is open, and contribute their experiences to the rest...in Scotland that’s still very limited...it would help the service user if I as a person of a BME background were to go to a hospital and see more different faces I would feel more comfortable...feel it was more alright" (Migrant/BME community representative).

Overall, migrant/BME representatives did not feel that the health sector had achieved sufficient diversity in its workforce. An interesting contrast is that the young migrant’s focus group did not think that it was necessary for healthcare staff to be of the same ethnicity as themselves. However, they did think that having intercultural awareness was important. They described this as having sensitivity to and an understanding of different cultural backgrounds.

**Participation of Migrant and BME Communities**

Several migrant/BME community representatives highlighted the importance of dialogue with migrant / BME communities and the need for the health sector to involve itself in community development work to make such dialogue possible. One respondent was heartened by what she had observed in terms of NHS representation within equalities forums in Glasgow: “I think it’s quite good – there is network attendance from NHS representatives in Glasgow. (...) That’s important and it’s good to recognise that.” Dialogue was also seen as key in helping to disseminate preventative health advice.

Another positive sign, mentioned by several respondents, was an innovative model of good practice in community engagement piloted in conjunction with the Black Leadership Network.15 This was contrasted with the usual consultation exercises. What is required, according to one respondent, is “really meaningful ways of discussing things with people, not just putting stuff out and expecting it to come back [in the form of consultation exercises], because it won’t.” The distinction between consultation and involvement in actual decision-making was echoed by another respondent:

| "It's relatively easy for an institution to put in place a policy which says “you must consult with this group”, and then “have you done this? Can you demonstrate that you've done this?” And it's a very different thing to bring about institutional changes which allow that group to have real involvement in decision-making and that's a much much harder process because inevitably it involves the institution itself giving up some power or the mainstream group giving up some power (...) It's just a whole different ball game when you're talking about [ethnic minority groups] having participation in decision-making and my experience is that those groups are very conscious of that distinction”.(Public Health practitioner). |

15 See section 1a pp.10-11.
**Intercultural Services**

The two ‘mainstreaming’ criteria resonated very strongly with respondents\(^{16}\): 1) Minorities should be regarded as integral to the general agenda; and 2) Despite mainstreaming, some consideration should be taken to where ‘special offers’ make sense or where specific forms of address should be chosen. Both were seen as important and inter-related. In some ways this inter-relation is evidence of competing interpretations of the mainstreaming concept. In some respondents’ accounts, mainstreaming services did not necessarily imply that those services were adapted to all groups’ needs equally. Instead, mainstreaming implied the risk of a ‘one-size-fits-all’ service, limiting BME patients’ choices for where to go for care.

“I think there’s a real danger that as we move to more and more mainstreaming – and everybody wants mainstreaming, and we all know it’s important to be part of the wider community – I think there’s a fear that the specific needs that are culturally important to a group, might be diluted, in an attempt to make a one-stop-shop, or one-size-fits-all” (Migrant / BME representative).

This interpretation of the mainstreaming concept is at odds with how the term is understood in documentation produced by NHS Health Scotland,\(^{17}\) stating that “[Mainstreaming] is about recognising that any policies which affect people (and most do) are unlikely to be ‘equally neutral’. It is not about treating everybody the same, but about taking account of different needs and realities and, through that process, developing policies that are sensitive to the diversity of the community.”

Interpretations of the concept aside, some respondents did note the tendency for specialised services to be closed down and their staff transferred to the mainstreamed service, where they then become the resident BME “expert”; this puts “huge pressures” on these staff and risks valuing them only for their ethnic background.

**Research and Knowledge Exchange**

It is clear from the actions described in sections 1a and 1b that research and ethnicity monitoring is crucial in any strategy which aims to make services more open to Migrant / BME groups and to reduce health inequalities experienced by those groups. Research is required in several areas, including but not limited to: the demographic profiles of local BME communities; disease prevalence and mortality rates among different groups; access to and use of services; and employee data (applications, current staff, promotions, leavers, disputes etc.). Getting good reliable data is a challenge.

“It’s difficult to always produce something that is strong and can give you hard evidence (...) That’s my fear for most things like this, which are really brilliant ideas, it’s good work, it’s work

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\(^{16}\) The full set of criteria is found in Appendix 2.

\(^{17}\) ‘Checking for Change’ (NRCEMH, 2005:116).
that needs to be done, but at the end of it, it may become quite bland, because it’s difficult to get solid responses and difficult to measure properly what the impact is” (Local activist).

What is fundamental in good data collection and analysis is ethnicity monitoring, ideally linkable to census and mortality data (Bhopal, 2007). This can be considered a sine qua non for addressing ethnic health inequalities. This requirement is missing, or at least not explicitly formulated, in the criteria developed during the course of the Moving Societies Project, and respondents urged that it be included. The current set of criteria on research (see slide 9 in Appendix 2) was felt to be important,

“but it seemed to be about building the evidence base and I wondered where monitoring comes in in all of the intercultural opening, which is a different use of information and evidence, and it didn’t seem to be covered at all, whereas in Scotland we would say that that’s a very important part of the work” (Migrant / BME representative).

**What’s Missing?**

In addition to the absence of ethnicity monitoring in the Moving Societies criteria, respondents also pinpointed three further items which they felt were indispensable to intercultural opening and equality but which did not feature on the Moving Societies criteria list. Human rights is not mentioned in the criteria, and one respondent wondered “what other countries are doing and whether they see human rights and the UN convention as being integral to all of this or not, because it’s something we’re starting to grapple with in Scotland.” The potential of equality impact assessments to contribute to intercultural opening was also flagged as one practice which might be included in future criteria. Finally, one respondent commented that she didn’t feel that these criteria were coming from a standpoint which acknowledges that institutional discrimination exists in partner countries. If this is not a starting point of the research, it risks being in “a vacuum”. This comment about institutional discrimination was also highlighted by several respondents when asked what the barriers to intercultural opening in the health service in Scotland were. This is the topic of the next section.
Part 3) What are the Barriers to Intercultural Opening of the Health System in Scotland?

Institutional Discrimination and Public Discourse around Equalities

Lack of understanding of what institutional discrimination means was stressed as a barrier to intercultural opening in the NHS. The Checking for Change toolkit followed the Macpherson Report into the death of Stephen Lawrence by defining such discrimination as “the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin” (NRCEMH, 2005: 116). One respondent mentioned that this indirect, institutional form of discrimination – in her words “the hidden subtle messages that are given, and undermine” – is too often masked or passed off as bullying or harassment, or is simply not reported. Another felt that “unless you can get health boards to also acknowledge that there is a problem [i.e., institutional discrimination] in place it is very hard to get anybody to change their practice.” This lack of understanding was attributed to a certain complacency: “we make a lot of assumptions that we’ve had the legislation for over 30 years (...) that doesn’t necessarily always mean that [staff] really understand [institutional discrimination].”

Terminology is also central here: how policy is worded and debated at the national political level does have an influence according to some Migrant / BME representatives. This may be compounded by the increasingly restrictive political rhetoric that has turned from the celebration of diversity in multiculturalism to a discourse of cohesion that stresses the need for groups to show unity and loyalty to the UK.

“My personal view and experience is that in recent years because of the pressures of the economy...of immigration...of poverty...of employment...all these pressures are contriving to create much more intense stress for equality. I think there is much more opportunity to highlight difference in a negative way than in a positive” (Migrant/BME community representative).

For example, the shift in terminology and discourse from valuing diversity to focusing on social cohesion may be interpreted by non-BME staff as a signal that BME patients are now expected to adapt to services aimed at the needs of the majority. It can also lead to resistance to the idea that intercultural opening is a two-way process. Several respondents noted the potential for resistance from within an institution to the idea that the majority needs to adapt too:

“I think that a major obstacle and something that slows [intercultural opening] down is the willingness of people within the institution to engage with the process, and that includes people at every level. (...) You might have quite a high level of commitment even at quite a senior level within the institution, but it going to be very hard to bring about change unless everyone within the institution has got to a point where they are willing to embrace that change, and to see it as something which is useful. So I think that's probably the biggest obstacle. Intercultural opening requires change or adaptation on both sides, there is always an assumption that migrant populations are going to have to adapt, no one thinks that that’s not appropriate but I think there
is a lot of resistance within the host community to the idea that they may also need to adapt and that’s the biggest obstacle to intercultural opening” (Public health practitioner).

**Compliance Culture can lead to Defensiveness**

Respondents noted that sometimes compliance with the legislation seemed to stop short of a change in culture or attitudes. A legal approach can mean that institutions become defensive and concerned only with compliance in a way that obstructs open dialogue between different groups, preventing progress towards race equality. One example mentioned in the practitioners’ focus group was data collection without clear aims for how that data is to be used. They felt there may be a need to rationalise the gathering of data and to ensure that the functions of monitoring are made clear and can be clearly communicated. “It’s only now that we are looking at the actual evaluation part...we get the information [data] but what do we actually do with it? What can we use it for?” (Response from practitioner’s focus group)

There was also an impression among Migrant / BME representatives that criticism is not always welcome, and a fear that this can have implications for third sector organisations seeking funding. The worry was that funding bodies prefer to be “stroked, courted” – not criticised. This leads to a general dilution of criticism and defensiveness in the voluntary sector. Hence the proposed solutions sometimes are the easy solutions, "solutions that people want to hear (...) criticism is not called for, is not welcomed , valued (...) What gets put out to the public is watered down, is very tame, (...) trite stuff," according to one Migrant / BME representative.

**Training too can be a Barrier if driven by Compliance**

While the practitioner’s focus group believed that some diversity training could be excellent and was needed, they noted that the need for this training competed with all kinds of other professional training, and that it was difficult to have it prioritized. Both migrant representatives and some of the practitioners noted that while the race equality duty meant that equality or diversity training had become more prevalent it continued to be of variable quality and there remained the difficulty of the training being a ‘tick box’ exercise, delivered only because it was required.

Counter-intuitively, training programmes – if the aims of training are not explained and prioritized – can also create barriers. One individual, with experience of minority ethnic health in New Zealand, commented that the introduction of compulsory equality training in that country "sometimes just produced resentment and a kind of resistance among some staff members just because it was compulsory and they didn’t see the relevance of it and I think in that context it can be a bit counterproductive. On the other hand, if it comes along later in the process, and it’s delivered in such a way that people can see it as being meaningful and maybe helpful to themselves, as well as to the organisation, I think it can be a much more useful thing."
Training may be counter-productive if limited to just one day of training on diversity. Not all of the issues can be grasped in this time: “it can’t possibly cover everything, it only touches on certain things” (Migrant / BME representative). Furthermore, the superficial knowledge gained can actually lead to staff making involuntary but offensive faux-pas.

“I've seen people making an attempt because they've had a little bit of training, they've maybe had a one-day training course on equalities and diversity (...) and they come back and they actually make a faux pas. (...) So a little bit of knowledge is quite dangerous sometimes. If you’re going to do it, do it properly, train folk right” (Local activist).

**Lack of Enforcement can Reinforce Institutional Resistance to Change**

In the experience of some Migrant / BME representatives, lack of funding and time are sometimes put forward by NHS managers to justify lack of action. "Achieving things on the ground often to me seems to be that that some people have chosen not to do certain bits of it." This is where a lack of meaningful enforcement kicks in according to one commentator:

"At some place along the line somebody has got to take responsibility for having the imagination to see how things should be working, and then following it up, but I think that a lot of organisations don't want to have that imagination. They don't have the time, they don't have the money, is what they keep saying, and yes they are right, however: how long is that excuse going to be used for?" (Migrant / BME representative)

One element which two respondents felt was missing in the criteria was the lack of enforcement or sanctions for institutions which do not meet the targets in these criteria. Several migrant/BME representatives suggested that race equality targets should be part of the key government HEAT targets\(^\text{18}\) that the health sector focuses on. It is to be noted that the target and assessment landscape is – like the performance evaluation field in relation to Checking for Change – shifting at present. A recent review indicates that HEAT targets will soon be realigned to mesh with the priorities of the new Quality Strategy.\(^\text{19}\) According to respondents, If intercultural opening was given more priority through enforceable targets then frustration at the slow rate of change due to lack of sanctions would evaporate.

**Focus on the Individual Bio-Medical Causes of Inequalities, not the Structural Causes**

A final health-specific barrier (in contrast to the other barriers here which can affect other sectors in addition to health) was mentioned by two respondents, who noted that some clinical personnel continue to see inequality very much in terms of a medical model (i.e., an individualised biomedical perspective. Such a perspective can be blind to structural features in society which

\(^{18}\) For more information on the HEAT performance measures agreed between the Scottish Government and health boards see: [http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273](http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273)

\(^{19}\) For details of the Quality Strategy, see: [http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality](http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality)
may also lead to inequalities and block intercultural opening. This state of affairs was contrasted with New Zealand and the United States, where the debate has moved on significantly to focus more on structural causes - be they at the institutional or socio-economic level. However, in Scotland, according to one Migrant / BME representative, there are still “very few examples of that sort of – seeing it from a wider perspective – it’s much more about what happens in A and E [Accident and Emergency hospital services] and what happens in the GP practice, but you can’t have [a clinical perspective] without [a societal perspective], because the NHS mirrors society... they’ve got to think laterally a bit more, or creatively.”
Part 4) Outlook: Recommendations for the Future

The NHS mirrors society. Inequalities in society are a challenge for the NHS, but the scale and reach of the NHS also mean that it has a huge potential to contribute to a more integrated and equitable society. As Scotland’s largest employer, if intercultural opening can be advanced within the NHS there will be a significant multiplier effect for the rest of society.

One of the aims of the Moving Societies towards Integration project was to derive potential best practice which promotes intercultural opening. In Scotland several examples of good practice in intercultural opening and race equality were observed. These form the basis of the following recommendations to actors in the Scottish health sector as well as to the project’s European partners, and are based on what respondents said they hoped to see happen in the future.

Our research began with the proposition that the legal framework of the race equality duty is a key ingredient in advancing intercultural opening. Respondents agreed that much progress has been made in terms of process – policies, strategies, guidelines – and the race equality duty has been an indispensable catalyst for this. However, less progress has been observed by actors on the ground in terms of outcomes.

With the goal of advancing intercultural opening in the health sector in Scotland and Europe, we recommend that the following practices and principles be pursued in the future:

- The equality duty is powerful in its requirements for workforce monitoring, equality impact assessment, and ethnicity data in terms of service use and health outcomes. These practices correspond to three domains which respondents judged to be particularly relevant for intercultural opening – workforce diversity, access to and content of services, and research. It is important that these three practices are pursued to full effect in future to ensure better outcomes for BME patients.

- Building ethnic health inequality measures into key government targets would likewise be a powerful message that governments are serious about race equality and intercultural opening.

- Legal frameworks and targets are crucial but not enough on their own; they are necessary but not sufficient conditions for intercultural opening and race equality. The value of the legal framework is its catalytic function as a ‘baseline’ for more systematic intercultural opening. Intermediary bodies like the Equality, People and Performance Directorate (EPP) can then exploit the opportunity structure provided by the legislation to promote and facilitate organisational change beyond mere compliance.

- Systematic good practice across the full spectrum of intercultural criteria is embodied in the EPP itself, as the evaluation of the organization against Schröer’s criteria in the case study section showed. Respondents identified the EPP as a very valuable if not unique resource providing support to health boards and developing innovative practices. The earlier call for lateral thinking and creativity – in preference to unimaginative over-reliance on legal...
frameworks only – is one which EPP staff will no doubt welcome and recognise in their own work.

• Creative and innovative responses are also evident regarding the model of engagement with Migrant / BME communities which was drawn up between health boards and the Black Leadership Network in 2008/9. Migrant / BME representatives believed that it would be beneficial for all stakeholders if this model of good practice could be rolled out on a wider national scale.
Appendix 1. Documents Consulted in this Research


NHS Health Scotland, Equalities and Planning Directorate, *Work Plan 2008/09*

NHS health Scotland, Directorate of Equalities and Planning: *Reporting Programme* (extract from full business plan)

NHS Health Scotland, *Delivering Equal Services to Black and Minority Ethnic Communities in Scotland – Proposal for a Race Equality and Mental Health Programme 2008-2011*


Scottish Executive (2002) *Fair For All*, Edinburgh: Scottish Executive


Scottish Executive (2004) *New Scots: attracting fresh talent to meet the challenge of growth*, Edinburgh: Scottish Executive


Appendix 2. ‘Moving Societies’ Criteria for Intercultural Opening

Slide 1

1. Workforce / Staff / Professionals working in the sub-system:
   - A culturally diverse team and/or interculturally-aware employees at every level of the organisation, especially in decision-making positions (not only in positions related to ‘migrants’)
   - Diversity and intercultural competence of the staff should be complementary and take into account the size of the organisation – not every organisation can be representative
   - Recruitment strategy for employees of migrant/minority background, to take positive action and level out imbalances in applications (e.g. advertising in specific media)
   - Integrating intercultural sensitivity as a criterion in the recruitment process
   - Every organisation should define intercultural competence for their staff and find systematic tools to assess it
   - Professionals of migrant/minority background in visible positions as role models.
   - Making systematic use of the existing intercultural competence of the workforce
   - Job shadowing to make experience in different jobs possible

Slide 2

2. Intercultural Trainings
   - Intercultural training should include values, self-evaluation measures, cultural sensitivity, gender sensitivity, recognizing racism and intervening, and language skills.
   - Training should be specific to the job profiles in order to be useful in everyday work
   - The target group for training should be diverse and include all positions and fields of work - including management - to promote a culture of sensitivity
   - Training should be systematic and continuous
   - Training should be financially secured and sustainable
   - The impact of training in the work context should be measured
   - Training resources should be diverse (on-line, e-learning, personal learning, seminars)
   - Intercultural training should play a role in professional education
3. Policies / Tools for Advancing process of opening:

- Development of strategic policy for intercultural opening, administered by an intermediary expert contact body for advice and support, which is linked to all relevant ‘sub-ordinate’ institutions
- Policy should incorporate a mainstreaming process to mainstream intercultural issues
- Development of policy involves different stakeholders (incl. migrant organisations) and makes use of existing know-how
- Policy development uses and standardises good practice project experience
- Use of evaluation measures for implementation and impact of policies
- A central resource and training centre to allow local communities and individuals to further develop intercultural skills and openness
- Policies should be communicated to the general public

4. Steering / Management / Internal organisation:

- Clearly stated commitment from the management of an institution to implement intercultural opening at every level
- An environment of equality and participation of employees in decision-making, allowing circular communication (bottom-up, top-down)
- An official complaints procedure to enable adjustments to intercultural opening strategies and to enhance communication
- Self adjusting systems that develop intercultural opening strategies in the every day work situation (flexible systems responsive to change; a “learning organisation”)
5. Partnerships between organisations and Networks:

- Organisation maintains multiple contact and cooperation structures for exchange of know-how, good practice, access to and knowledge about target group
  - with similar organisations (horizontal)
  - with other organisations/associations especially in local community (vertical/cross-professional: migrant organisations, schools, youth centres etc. – non-professional associations should be included!)
  - with individual actors (parents, professionals, etc)

- A central organisational body could assist in thematic networking. This includes networking professionals outside institutions to increase their participation in institutions

- Grant schemes should support thematic networking between organisations (as a recommendation)

6. Intercultural Contents / Services:

- Mainstreaming intercultural contents/services: Minorities/migrants and respective issues should be regarded as integral to the general agenda, and not merely a ‘special offering’

- Despite mainstreaming some consideration should be taken to where ‘special offers’ make sense, or where specific forms of address should be chosen to include migrants/minorities

- The notion of migrants as people with multiple identities should be promoted, i.e., not a single homogeneous group, not reduced to their ‘migrant’ status

- Intercultural content and services should be further developed by staff in exchange with the intercultural surroundings of their work area (they should not be rigid)
7. Mediation with target group:

- Strategic involvement of mediators in institutions
- Mediators to bring services to the target group and lower thresholds for participation
- Mediators should be specifically trained in the work area
- A mediation strategy specific to the work area should be developed
- Mediators should have direct experience in intercultural matters (not only knowledge)
- Mediators should not be merely voluntary

8. Participation of target group:

- Developing practices and structures that encourage target group to participate in the planning and decision-making of institutions and services
- Maintaining participation structures which involve a broad base of the target group (not always the same people)
- Evaluating participation structures and feedback procedures in order to guarantee participation
Slide 9

- 9. Making use of research / Dissemination and learning:
  - Nationwide and transnational dissemination of evidence and good practice to relevant actors for practical implementation
  - Regional dissemination of good practice to make experience accessible to practitioners
  - Trans-regional (also transnational) dissemination of research and good practice to allow exchange between similar regions
  - Trainings, workshops etc. for institutional professionals to share practices, projects and strategies
  - Making use of a national observatory which collects data (if observatory exists)
  - Encourage cooperation between public administration and research bodies to disseminate information

Slide 10

- 10. Other:
  - Publication of practical handbooks for practical implementation in institutions
  - Reaching out to target group: decentralise activities to reach target group where they are
  - Interaction of different social groups in public/half-public institutional spaces should be encouraged
  - Information about services and rights and responsibilities should be brought into the communities and their (informal) institutions and associations
  - Balance the usage of the term “target group” with the term “audience” or “user/clients”
Appendix 3. Schröer’s Quality Criteria for a Successful Process of Intercultural Opening

Intercultural orientation of the organisation
- Is there a leading concept in the organisation, which mentions intercultural orientation?
- Are there operational goals to achieve this?
- Are there measures and initiatives?

Structures of sustainability
- is Managing diversity / intercultural opening understood as a top-down management task?
- Is there an organisational unit, a contact person to support this?
- Is this structure supported by sufficient staff and financial resources?
- Are there network structures in the organisation which allow bottom-up participation?
- Is the process of intercultural opening understood as a mainstreaming strategy (as an organised learning process which is based on exchange, networking and spreading results with the aim of making structural changes?)

Qualification of staff
- Are there measures for intercultural sensitisation and qualification of staff?
- Do these measures adhere to at least minimum standards (goals, competences of suppliers, target groups etc.)?
- Are there measures for targeted gaining of staff to represent diversity?

Clients
- Are the needs of clients known (through surveys etc.)?
- Are access hurdles and inhibitions identified and addressed?
- Are new target groups / clients addressed, and does the organisation make use of existing intercultural potentials?

Culture sensitive evaluation
- Are the goals operational, are there indicators to check achievement of aims?
- Do these indicators take into account the special circumstances of multi-ethnic staff and clients?
- Is there institutionalised reporting and monitoring?
- Is there evaluation of the effects of measures of the process of intercultural opening?

(Source: Hubertus Schröer (2007): Interkulturelle Öffnung und Diversity Management; IQ-Schriftenreihe Band 1, pp. 63/64; translation by CJD Eutin)
Appendix 4. Methodology

The fieldwork undertaken for this project included two focus groups (one with practitioners and one with young migrants (aged 16-27) and two series of interviews with representatives of migrant/BME organisations as well as people from outside the third sector with experience of health service research and policy engagement. The practitioner focus group was held on 17th June 2009 and the focus group with young migrants on 11 August 2009. The first series of 4 interviews took place between 11 August and 7th October 2009. The second series of 5 interviews took place between 5 April and 29 April 2010.

The participants of the practitioner focus group were sourced through the equalities ‘contact points’ of the Equalities and Planning Directorate. Consequently this was an extremely well informed group with each member playing a role in delivering on equalities and diversity outcomes within their health board.

The participants for the young migrant’s focus group were sourced through contacts with migrant community organizations and providers of specialist services to migrant/BME groups. Finding suitable participants who fell within the age group and had sufficient experience of health services was difficult and we had a rather large group of participants with the aim of getting a broad range of opinion and experience.

The individual interviews with migrant representatives were conducted with migrants who worked in organizations that either represent migrant/BME interests or provide specialized services for migrants or BME groups. The interviewees also had professional experience of the health sector and the issues this raised for migrant/BME communities thanks to their involvement in specialist health service provision, research, policy engagement or a combination of the three. To enable representatives to give full and frank accounts of the issues they were interviewed in a personal capacity rather than asked to provide the formal position of their organisation.

The focus group participants were asked to complete datasheets to supply basic profiles including age, gender, education and self-identified ethnic group. The response rate was not 100%, but most participants provided answers to most questions. Among the practitioners the vast majority was female and identified as ‘White Scottish’ (four female, one male; three ‘White Scottish’, one ‘Black Other’, one Non Response (NR)) and a clear majority were born within the EU (three in Scotland, one in the EU, one NR). The ‘Young Migrant’ group was more mixed in terms of origin: they listed ethnicity as three White Other, one African, one Asian, one Mixed and two NR. In terms of country of birth two were born in Poland, one in Kenya, one in Venezuela, one in Finland and two NR. The group included two male and six female participants. All were born outside the UK, but had arrived in different periods with the year of arrival ranging from 1989 to 2005.