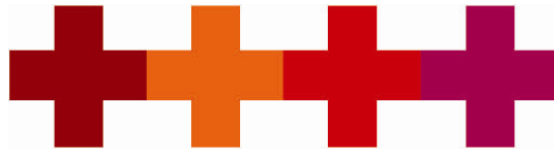


race for health



a transformational change programme

Bradford and Airedale TPCT Peer Review

6th - 7th November, 2006 Outcome paper

1. Executive Summary

- 1.1. The Bradford and Airedale Teaching PCT (BAAtPCT) Peer Review took place on 6th and 7th November 2006, and this paper sets out the review team's findings and recommendations. It is drawn from discussions on the day, and as such will provide – much like the day itself – a set of 'informed reflections' of BAAtPCT's work in the area considered.
- 1.2. The thematic focus for the Peer Review was: *How can the newly formed Bradford and Airedale Teaching PCT enhance Black and Minority Ethnic patient engagement with diabetes care, as it interfaces with both Primary Care and the family?*

Overview

- 1.3. Prevalence rates of diabetes within the South Asian Community represent a significant challenge to BAAtPCT both in terms of engagement with the local community in the prevention agenda and the provision of effective and culturally competent services to patients who have diabetes. Type 2 diabetes is six times more common in the South Asian Community than the White British population, while 60% of the people living in the area previously covered by Bradford City PCT are from the South Asian community. This area also has the second highest estimated levels of diabetes in England for the under 30 age group.
- 1.4. The review team heard that levels of awareness within the South Asian Community regarding diabetes have increased over recent years, however evidence that this has resulted in behavioral change is scant. The time is now opportune for the newly formed

BAtPCT to make reducing levels of diabetes in the South Asian Community and providing culturally competent services to those already with diabetes as key priorities for the PCT.

- 1.5. Leadership needs to come from the executive as well as middle management level if significant change is going to occur. Encouragingly, BAtPCT's new leadership made a point during the review of emphasising its 'total' commitment to maintaining a strong organisational focus on the equalities agenda and ongoing support for innovative work around diabetes. BAtPCT's ability to follow through on this expressed commitment will be crucial if current momentum is to be maintained. In this context, when future recruitment of BAtPCT's board occurs, knowledge and expertise of race equality issues, as well as a commitment to tackling them, should be considered as key attributes for new members.
- 1.6. The review team saw several examples of innovative projects which aimed to engage the South Asian communities in the diabetes agenda. However these initiatives tended to operate around the periphery of mainstream diabetes services. These dynamic initiatives need to be brought into the core of diabetes service provision and form part of a joined up and systematic plan which aims to reduce the prevalence rates of diabetes and improve service provision.
- 1.7. It was felt that the BAtPCT Thinking Partner and CEO should work together on an official response to this outcome paper which would include an action plan on how BAtPCT would move forward to address the challenges outlined in this paper.
- 1.8. If BAtPCT can successfully rise to the challenge of providing an effective diabetes prevention programme whilst also providing culturally competent services to the South Asian Community, then there is a real opportunity of BAtPCT becoming a centre of excellence in this area for the UK.

Evaluation and Data collection

- 1.9. A variety of evaluation methods, including qualitative techniques, needs to be used to assess the effectiveness of new initiatives which target the South Asian community. This will help to assess their impact, and the findings from these evaluations then need to be fed directly into the commissioning process and the provider arms of BAtPCT

- 1.10. The team urges BAAtPCT to keep the development of robust, systematic **patient profiling/ethnic monitoring** in primary care as a key work priority.
- 1.11. Commissioners need to ensure that provider agencies collect good quality data to **support the development of an evaluation culture**. A patient profiling requirement should be incorporated into all Service Level Agreements, and all PCT referral forms/patient records/IT systems should support the collection of this information.

Recommendations

- 1.12. BAAtPCT must ensure that progress on race equality generally, and work on diabetes specifically, is **consolidated and extended** across the unified PCT.
- 1.13. BAAtPCT should consider expanding its use of **community development approaches** and recruit more people into its workforce from target communities.
- 1.14. The review team noted that many of the initiatives targeted at the South Asian community had focused on the family. However BAAtPCT also needs to target some **health promotion messages specifically at children**, as the area's large and expanding young South Asian population needs to hear appropriate messages on diabetes prevention.

2. Introduction and Theme for the Review

- 2.1. The Bradford and Airedale Teaching PCT (BAAtPCT) Peer Review took place on 6th and 7th November 2006, and this paper sets out the review team's findings and recommendations. It is drawn from discussions on the day, and as such will provide – much like the day itself – a set of 'informed reflections' of BAAtPCT's work in the area considered.
- 2.2. The team received an overview from BAAtPCT staff which included its Chair, Thinking Partner, Managers and Specialists from its Equalities and Diabetes Departments. The team also spoke to staff from various grades and departments/services, as well as members of a local community group. Members of the review team visited a retinopathy referral screening centre as an example of mainstream services and national programmes, as well as the

Khidmat Community Centre to examine some examples of prevention work. The review team also looked at how BAtPCT had evaluated the impact of its diabetes initiatives targeted at the South Asian Community.

Thematic focus

2.3. The thematic focus of the Peer Review was:

How can the newly formed Bradford and Airedale Teaching PCT enhance Black and Minority Ethnic patient engagement with diabetes care, as it interfaces with both Primary Care and the family?

2.4. The review team focused on three aspects of the PCT's diabetes work: prevention, implementing national programmes in a culturally appropriate way, and evaluation/measuring impact. Key questions included:

- What are the key success factors in designing and delivering effective diabetes health prevention programmes?
- How far has BAtPCT progressed over the last two years in developing culturally appropriate diabetes services, and what evidence of improvement can it show?
- How does BAtPCT measure the impact of its interventions, and how is learning from this being reflected in commissioning and service delivery?

3. Background and Context

About Bradford

- 3.1. The Metropolitan District of Bradford is in West Yorkshire, in the north of England. The district covers 141 square miles, two-thirds of which is rural. The population of the district is 473,400, of whom 80% live in the district's urban areas.
- 3.2. Compared to the rest of the UK, the population of Bradford is average in terms of its relative proportions of men and women, and has similar proportions of under-30 year-olds and over-65 year-olds. However, the district has high levels of under-16 year-olds when compared with other areas. Overall, population levels are forecast to rise over the next few years.
- 3.3. Some 24% of Bradford's population are from Black and minority ethnic (BME) communities – primarily of Pakistani heritage with smaller Indian and Bangladeshi populations. However, the proportion of BME people is closer to 67% in the central Bradford City area, the focus for the review (see below).
- 3.4. Historically, Bradford's economy was based on textiles and engineering. The collapse of these industries in the late 1970s and early 1980s had a significant impact on the prosperity of the district, the legacy of which underpins a number of current challenges in the area.

Deprivation in Bradford

- 3.5. Bradford shares many characteristics with other English conurbations and inner cities: educational qualifications, levels of employment, access to private cars and health are all poorer than the average for England and Wales. Bradford's incomes rank as the 5th lowest local authority in England, and the index of multiple deprivation (2004) ranks it the 30th most deprived council area in England out of 388.
- 3.6. Unemployment is at its lowest level for some time, but levels of involvement in formal economic activity remain relatively low in some areas. This is reflected in overall employment levels: 68% for the district, compared with 77% for the region and 79% for England as a whole. GCSE attainment is significantly below average, and the district has an above average rate of violent crime.

- 3.7. Child poverty in many parts of Bradford is also widespread. In University, Little Horton, Bowling, Toller and Bradford Moor, over 70% of children live in low income families. Across Bradford, 44% of children live in such families, compared with 27% nationally. Almost one in four homes lack one or more of the basic amenities of central heating, sole use of a bath, or inside toilet (compared with 8% for England and Wales).
- 3.8. Yet these generalities conceal many differences; the contrast between areas of higher and lesser deprivation is well recognised in Bradford. Bradford Moor and Little Horton are among the wards with the highest levels of deprivation in England, while Rombalds and Ilkley are among the wards with the lowest.

Bradford and Airedale Teaching Primary Care Trust

- 3.9. Up until 2006, four Primary Care Trusts (PCTs) existed in Bradford: Bradford City tPCT, Bradford South and West PCT, North Bradford PCT and Airedale PCT. However these were formally merged into a single, district-wide PCT in October 2006 – Bradford and Airedale Teaching Primary Care Trust. There are also two main Acute Hospital Trusts in the district, as well as Bradford District Care Trust.
- 3.10. BAAtPCT has a new Chair and Chief Executive and is currently in the process of appointing its senior management team. At the time of the review, the structure of the new PCT's teams and services were still under development; however, some services – including both diabetes nursing and dietetics – were already being delivered on a district-wide basis prior to the merger.
- 3.11. The former Bradford City tPCT became a member of the Race for Health programme in 2003, and in 2004 decided to focus its 'transformational change' programme on looking at diabetes within the area's South Asian population. As well as specific work in this area, the goal was for wider learning to be shared and embedded throughout the organisation. The commitment to Race for Health is being carried on by the new Bradford and Airedale PCT, again with a particular focus on central Bradford. For the purposes of the review, discussions focused on the former Bradford City area.

Tackling health inequality

- 3.12. Bradford is a Spearhead local authority, and tackling health inequality is a key priority for the PCT. Life expectancy in the area continues to be significantly below the national average for both males and females, and is generally lowest in the most deprived wards.
- 3.13. As well as a high prevalence of diabetes (see below), some of the most challenging health problems in Bradford are:
- Bradford has one of the highest rates of death for children under one year of age in England (7.2 per 1000), with 28% more children dying than the average for England.
 - Death rates from smoking, cancer, heart disease and stroke are significantly above the national average (although the latter two are improving at much the same rate as nationally).
 - The proportion of residents undergoing treatment for drug misuse is well above the national and the regional average.
- 3.14. An above average percentage of Bradford's residents describe their health as 'not good', although a lower proportion than average are being treated for severe mental health problems. Poor health experience can largely be attributed to deaths from cancer, heart disease and strokes, for which the three major preventable risk factors are smoking, diet and lack of exercise. Much work is taking place in the district across these three areas, particularly in community settings, schools, and workplaces, with a focus on disadvantaged communities.

Diabetes in Bradford

- 3.15. There are over 20,000 people with diabetes across Bradford and Airedale – a prevalence of 5% – and up to 90% of them have Type 2 diabetes (nationally, 85-95% of people with diabetes have Type 2).
- 3.16. Type 2 diabetes is six times more common in the South Asian community than among White British people and its prevalence in Bradford is due in part to its demographic profile (research has also shown a link with deprivation). Type 2 diabetes usually appears in people over the age of 40, though in South Asian and African-Caribbean people it often appears after the age of 25. However, recently, more children are being diagnosed with the condition, some as young as seven. The area previously covered

by Bradford City tPCT has a large young South Asian community; approximately 60% of the area's 150,000 people are South Asian, and 60% of these are under 40. The area has the second highest estimated levels of diabetes in England for the under-30 age group – the prevalence in some practices within this area is as high as 7%.

- 3.17. In most cases Type 2 diabetes is linked with being overweight. It can be prevented by adopting a healthy diet, undertaking adequate physical activity, and maintaining a healthy weight. Obesity is therefore an increasingly important risk factor in causing higher prevalence of diabetes and heart disease in Bradford.

Commissioning and delivering effective diabetes care

- 3.18. The Department of Health's National Service Framework for diabetes (2003) and the new GP contracts place PCTs at the forefront of commissioning and delivery of structured diabetes care. In Bradford care has developed since the late 1990s, and is presently delivered within a three-tier system:

Primary care	→	Primary care diabetes clinics (in General Practices)
Specialist care	→	Satellite clinics (for patients requiring insulin therapy)
Complex care	→	Hospital (for patients with complex care needs)

- 3.19. Where possible, movement is encouraged through the levels in both directions, which is unlike the one-way referral process historically adopted in diabetes care. The aim is that patients will receive structured care at the appropriate level to their clinical need; the majority are monitored through their General Practitioners (GPs), thereby reducing the burden on satellite services and secondary care.
- 3.20. The PCT's dedicated team of diabetes specialist nurses (DSNs) provides training and support to GPs and practice staff, operates satellite diabetes clinics and supports a unified on-call system that links community and hospital-based DSNs. Additionally, all GPs in the district have access to podiatry services, dietetic provision and retinal screening.

Achieving 'cultural competence'

- 3.21. As well as having an increased genetic susceptibility to diabetes, religion, culture and language can play a significant role in South Asian patients' management of the disease. At the same time, lack of awareness among staff 'one-size-fits-all' models of care have tended to leave these communities at a considerable disadvantage in the past.
- 3.22. Accordingly, the delivery of culturally appropriate preventative work and care for diabetes patients from ethnic and religious minority communities has been a priority for Bradford City tPCT over the last few years, and will remain a challenge for the new BAtpCT. Efforts to address this to date have included investment in training for PCT staff and other health workers; targeted public health initiatives; the recruitment of language-support workers to work specifically in the area of diabetes; and the production of patient information leaflets in a range of community languages (such as Urdu and Bengali).

4. Findings

- 4.1. The peer review team received presentations from, and held discussions with, BAAtPCT staff in plenary. The team also broke up into smaller groups and had the opportunity to look at three areas of the PCT's work in more detail. The content of these meetings are summarised below.

Strand one: Making targeted prevention work more effective

- 4.2. For the PCT, effective prevention work is likely to be much more cost-effective than treatment in the long run, especially as diabetes is a chronic illness. In most cases, Type 2 diabetes is linked with being overweight. It can therefore be prevented by adopting a more healthy lifestyle – having a healthy diet, undertaking physical activity and maintaining a healthy weight.
- 4.3. Recognising this, BAAtPCT has been attempting to replicate a project which helps prevent and manage diabetes by educating people about healthy eating. Based around a programme of guided 'supermarket tours', the PCT has tried to adapt it to target South Asian people. Some members of the review team had the opportunity to visit the Khidmat Community Centre, where they heard more about the project from Helen Mitchell, a Diabetes Specialist Dietician for BAAtPCT, and met a group of local South Asian women attending a drop-in diabetes session at the centre.

Supermarket tours' – educating the community about healthy eating

- 4.4. BAAtPCT has delivered a programme of 'supermarket tours' in three of the main supermarkets in Bradford – Asda, Morrisons and Tesco – as a way of educating local people about adopting and maintaining a healthy diet. The tours are run by a diabetes dietician but anyone can attend. The dietician takes people around the supermarket, explaining which foods should be eaten as part of a healthy diet and answering any questions people have.
- 4.5. The project has had a good take-up by local people; some members of the South Asian community have attended but it has been mainly White British people who have booked onto the tours. Given that the South Asian community has a much higher prevalence and risk of diabetes, and following suggestions from community leaders, BAAtPCT decided to run the tours in specialist Asian supermarkets.

- 4.6. This suggestion was met by enthusiasm from the shop owners concerned, who were very positive about the project. BAAtPCT set about promoting the Asian supermarket tours by producing leaflets and displaying them in community venues such as GP surgeries, libraries and community centres and in the supermarkets themselves. PCT staff had consulted with local South Asian people to find out which days and times would be the most suitable, and took community leaders on the tour to see how what they thought of the experience.
- 4.7. However, in spite of their efforts, no one has yet turned up to take part in a tour. They are advertised in the same way as the diabetes awareness drop-in sessions that the PCT organises, and both these and a programme of 'cook and eat' sessions are relatively well-attended. PCT staff are therefore finding it difficult to understand why the take-up for this activity has been so low, particularly when members of the South Asian community seemed to be so positive about their introduction. Given that the PCT has invested a lot of time in the project and is eager for it to succeed, staff asked the review team to think about looking at the possible reasons for the low take-up. The team's suggestions were listed in the findings and recommendations section.

Views from a group of South Asian women

- 4.8. Members of the review team were fortunate to speak to a group of local South Asian women who were attending a drop-in session on diabetes at the Khidmat Centre on the morning of the review. They spoke to the women about their awareness and experience of diabetes, and about methods of prevention. The key points that came out of this discussion are listed below:
- The women were aware that diabetes is more prevalent among the South Asian community, but they didn't know why they were more at risk and were trying to understand more clearly what they could do to prevent it. This was not something they had previously discussed with the health workers who come to the centre, yet they wanted to bring it up with the review team.
 - The women agreed that services are much better if they are able to access them in their own language – they did not realise that the PCT has a number of language support workers who can help with this.
 - The women had found out what they should and shouldn't use when cooking (e.g. limiting salt intake and using brown

flour) from their attendance at the drop-in sessions. They were aware that eating small amounts regularly was a good way of managing diabetes.

- Learning how to make the South Asian diet healthier was seen as important – one of the women stressed that she wanted to teach her children about their culture and wanted to give them culturally specific food.
- When talking about managing diabetes at home, the women frequently talked about avoiding sweet foods as one of the main difficulties. They said that it was not easy to resist when there were sweets in the home and other family members were eating them.
- The women said that they shopped in the halal supermarkets, but also used the bigger supermarkets such as Morrisons, which stock some products specifically for those who are diabetic (e.g. yoghurt).
- All of the women thought that the Asian supermarket tours would be really helpful, but none of them knew about those that the PCT had already piloted.
- The women recognised that they were not undertaking enough exercise, but found it difficult to do so. They said that exercise classes were sometimes held in the Khidmat Centre, but were too irregular and not promoted well enough. The women would like to see more exercise classes and to have the use of exercise machines.
- The women recognised the role of schools in educating children and young people in adopting a healthy lifestyle and said that they would support them doing more. The women suggested that children should be encouraged to pass the information on to their parents or that the school should write to parents informing them about what the children had learnt.
- When asked how best to reach out to communities, the women thought a door-to-door approach was best – they also recognised the power of TV and radio.
- When asked about literacy levels and whether it would be a problem if they were to receive a written letter, the women said that there tended to be someone in the family who could read so it was not usually an issue.

Strand two: Creating culturally appropriate services

- 4.9. For this strand, the review team wanted to see an example of how BAtpCT has progressed over the last two years in developing

culturally appropriate diabetes services (particularly in terms of implementing national programmes), and any evidence of improvement. The chosen focus was the retinopathy screening programme, which is subject to a national QOF (Quality and Outcomes Framework) target: 90% of diabetes patients must now be offered retinal screening each year.

- 4.10. Retinopathy is a common complication of diabetes, and occurs due to damage to the tiny blood vessels next to the retina. Left untreated it can cause loss of vision or even blindness, making early detection important. Diabetes sufferers are offered annual retinal photography (conducted by local optometrists) to ensure any deterioration will be identified early, and this is paid for and administered by the PCT.
- 4.11. Members of the review team visited the Retinopathy Screening Programme's headquarters at the Queensbury Health Centre in South Bradford, and met with the project manager and BAAtPCT's Nurse Consultant in Diabetes Care to discuss the programme's development.

The Retinopathy Screening Programme (RSP)

- 4.12. At the moment, anyone (over 12) newly diagnosed with diabetes in Bradford is referred to the Retinopathy Screening Programme by their GP, using a standard form produced by BAAtPCT. Once these details have been entered onto the programme's register, the patient is automatically sent a letter every 12 months. This invites them to phone the RSP call-centre and make an appointment for a screening, which can be carried out at their choice of four locations across Bradford – usually within two weeks. The letter is accompanied by a leaflet about retinopathy and retinal screening and an information sheet in English and Urdu from PALS (the Patient Advice and Liaison Service).
- 4.13. If no appointment is booked, a second letter is sent; if there is still no response, the GP is informed so that they can discuss it with their patient and the process will roll over until the following year (although the patient can be re-referred at any stage). Some patients do not attend the appointment that they have made; the optometrist will tell the RSP when this happens, the GP is advised and the process again rolls over until the following year. Patients can opt out of the screening programme if they wish, but this is discouraged.

Recent changes to the RSP

- 4.14. The RSP used to be paper-based, but in January 2006 the system was computerised. Under the old system, the patient was given a referral letter by their GP to take directly to an optometrist – however if this did not happen for any reason, the patient would fail to show up on the screening register. As well as centralising the referral process, the new system has several other advantages; it is faster and more efficient; the register can be more readily updated and expanded; patient information can be viewed ‘live’ by the RSP, GP and optometrist; and reports can be generated from the data-bank.
- 4.15. However, frontline staff are not currently able or instructed to interrogate the data from the RSP database (e.g. breaking down ‘Did Not Attend’ by age, gender, source of referral etc.). The team heard that this could be done by IT support staff on request, but it wasn’t clear whether this was being done on a routine basis to inform the development of the service, or whose responsibility it would/should be to request such analysis.
- 4.16. The district-wide RSP register has been put together from a variety of sources – for example, the former Bradford South and West PCT’s register was based on its podiatry records. Rather than try and shift all patient records onto the system at once, BAAtPCT has undertaken a phased transition which is now almost complete. Due to the NHS recruitment freeze, the RSP was staffed by temporary employees until October 2006. Now that a permanent team is in place the RSP team is to undertake a full validation of the register, and BAAtPCT anticipates that by the end of December everyone with diabetes in the district should be on the system.
- 4.17. In another big change, retinal screening used to be conducted using a manual ‘split lamp’ machine, but a new national target requires all screening in future to be carried out using specialised digital camera equipment (Bradford presently has four sets of this equipment). Achieving this will be a major challenge for the RSP and for the optometrists, many of whom will lose significant income as a result of the new policy. However, the PCT’s efforts to manage the switch have not gone unrecognised, its relationships with optometrists remain strong and the quality of Bradford’s RSP was lauded at the recent national retinal screening conference.

Ensuring the RSP is culturally competent

- 4.18. Visiting members of the review team were interested in learning what efforts the PCT had made to ensure that the RSP met the needs of Bradford's South Asian community, particularly those with language needs.
- 4.19. The RSP does not presently record information on ethnicity, religion, language needs or literacy, and neither the referral form nor the electronic template supports the collection of this data. Because of this, it is difficult to establish whether or how South Asian people's experiences of the RSP might differ from those of White British people. BAAtPCT staff explained that patient profiling/ethnic monitoring is a priority across the organisation and they have been assured that data at practice level will be fairly robust by 2007.
- 4.20. All RSP communications are currently conducted in English, either written or spoken. Although none of the call-centre staff speak community languages, they have found that patients who are not English speakers almost always have a family member who is able to make the arrangements on their behalf. Practice nurses can also book an appointment on a patient's behalf while the latter are visiting their GP. Where staff have identified that communication is an issue for a patient, they send a letter confirming the details of the appointment. Although this and the patient information leaflet are also in English, GPs are encouraged to discuss the retinal screening process in detail with their patients, and particularly those with language needs (GPs have access to language support workers through BAAtPCT). Staff explained that an interpreter is not normally required at the screening itself, as the process is brief and practical and does not involve any collection of personal data or care decisions by the patient.
- 4.21. Observance of Ramadan and celebration of Eid can have implications for Muslim patients undergoing retinal screening; RSP staff are clearly aware of these and where possible endeavour not to book appointments for these patients during the month of Ramadan. Some Muslim patients are uncomfortable taking the eye drops (given as part of the screening) while fasting,

and those whose appointments fall on Eid – which can be difficult to predict in advance – will often fail to attend.

- 4.22. When BAAtPCT looked at race equality in relation to the diabetes pathway in October 2005, concerns were raised that Muslim women who veiled their faces might be unwilling to remove them for retinal screening. Although to staff's knowledge this has not yet proved a problem, they could not say whether it might be a factor in some women failing to make or keep appointments. Although there are two female retinal screeners working in Bradford, this information is not volunteered to female patients. (Home visits have been possible in the past for housebound people, but the new digital equipment is not mobile enough to facilitate this. However the PCT is piloting a scheme for housebound patients which will cut across several service areas.) Around Ramadan and with female patients who wear the veil, practice nurses are encouraged to make an extra effort to explain what will happen during the screening process and discuss any concerns in advance.

Structured education for diabetes patients

- 4.23. During their visit to the RSP, review team members heard that the focus of BAAtPCT's diabetes team – while maintaining high-quality structured care – has now moved to the delivery of structured patient education that will meet the needs of all patient groups. A national target has been set that requires PCTs to move toward offering structured diabetes education to all newly-diagnosed patients; in Bradford this would translate to around 3,000 patients a year. Although more effective self-care would result in cost savings for the PCT down the line, this scale of delivery still has massive resource implications.
- 4.24. At present the intention is to offer 36 courses over the first year (catering for 360 patients) using the 'Xpert' syllabus. Developed in Burnley, Xpert has been chosen partly because – unlike the more common 'Desmond' diabetes education programme – it has already been delivered in Urdu. BAAtPCT intends to offer patients the Xpert course in English, Urdu and Punjabi and these are expected to commence in April 2007. However, prior to this staff will run through the course's content with GPs, practice staff and other related health professionals, ensuring that everyone working with patients will be giving them consistent messages.
- 4.25. An obstacle cited by staff to offering more diabetes structured education courses more often (best achieved by running shorter,

more intensive courses) is that many South Asian mothers find it a challenge to fit classes in with their daily prayers, morning, lunch and after-school runs and preparing the evening meal. Although this shows commendable levels of understanding, the team thought that staff could investigate whether childcare provision or other practical support could help to resolve these issues.

Strand three: Measuring impact and learning from the patient experience

- 4.26. Other members of the review team met with a group of representatives from BAAtPCT, covering the areas of Equality and Diversity, PALS (the Patient Advice and Liaison Service), Commissioning, Vascular Health and Diabetes Services.
- 4.27. According to recent research, only 2% of trusts are currently publishing the results of their Race Equality Impact Assessments. This may not mean that this work isn't happening, but systematic evaluation of the impact of policies on BME communities appears to be lacking. Impact Assessments are important to ensure services are 'culturally competent', for compliance with legislation and to promote what has been done.
- 4.28. The group initially discussed a range of examples from Bradford of good practice in engaging South Asian communities. Various initiatives were described to the team including:
- The '**Smiling with the Prophet**' dental health promotion programme: this was designed and delivered primarily by the dental health team, and involved targeted work with young people in Bradford schools and mosques. Although the original purpose of the programme was to encourage improved dental hygiene by linking it with the Muslim faith, many of the messages – for example around healthy eating – are also relevant to diabetes prevention. The diabetes team hopes that, rather than delivering a whole new programme that includes these and wider messages (e.g. promoting physical activity), an 'add-on' module can be designed to run alongside the existing programme.
 - A **customised physiotherapy programme**: aimed at reducing pain, this initiative encourages people to stretch regularly by linking exercises with the prayer positions relevant to their own religion. The programme has been successfully used with older people from the Sikh, Muslim and Hindu faiths and has received positive feedback.

- A health promotion advertisement on **Ramadan Radio**, which runs in Bradford during Ramadan: the advertisement, which was played three times a day, was in Urdu and featured a child speaking to their family about diabetes. Ramadan is seen as an excellent opportunity to raise issues around diabetes with the South Asian community and anecdotal evidence suggests that the advert resonated with its intended audience.
- **Project BEAT**: this is an initiative delivered by the Coronary Heart Disease (CHD) team, which involves finding ‘buddies’ for people who are undergoing cardiac care. As part of the project, the CHD team recruited a local market trader and trained him to help raise awareness of key health issues in the community. Despite having no previous experience in health, he was identified as a lever for change due to his strong links with the target community. His appointment has proved very successful, and the diabetes team now also plan to employ a community outreach worker. Although it is less realistic to ‘buddy’ newly diagnosed diabetes sufferers due to their large numbers, the diabetes team is learning from the success of the CHD team’s approach with Project BEAT.

Evaluation and monitoring impact

- 4.29. The group then heard about recent evaluation work, through which BAtPCT has tried to measure the impact of its diabetes interventions. These included an evaluation which provided a ‘snapshot’ of diabetes services in Bradford, drawing on the diabetes assessments of South Asian patients. The evaluation highlighted a lack of public health data in this area, and showed that GPs were not as involved in the assessment process as they could have been. A separate evaluation was carried out by the Health Foundation which found that, once South Asian patients had begun to access satellite diabetes clinics, they were more likely to get ‘stuck’ at this level of care and tended not to be referred back to GPs once their level of need had reduced.
- 4.30. However, members of the review team also heard that there was anecdotal evidence that South Asian communities’ behaviour was beginning to change to reflect health promotion messages. For example, health professionals had observed a significant increase in the number of South Asian women walking in Manningham Park, suggesting that encouragement to take more physical exercise may be having an effect among this key target group. However, at the moment this type of evidence is hard to quantify.

- 4.31. One area that was perceived to be under-evaluated/monitored is assessment of the patient journey - particularly patients' experiences when they initially access the diabetes service. There was also awareness among BAtPCT colleagues that the situation in Bradford was not static, and that once evaluations have been carried out and their recommendations acted upon the situation could have moved on.

Capturing patient feedback to PALS

- 4.32. Members of the review team heard that Bradford's PALS (the Patient Advice and Liaison Service) currently provides little information about patients' experiences of diabetes services, with the majority of complaints focused on issues with GPs. PALS is able to pick up patterns around the patient experience if they are complaining about particular issues regularly or at specific locations or times, but apart from observing a reduced level of complaints it is less likely to find out about issues that are being resolved before they reach PALS.
- 4.33. The PALS service is also struggling to engage 'hard-to-reach' groups; for example many patients in these groups apparently don't know how to complain about GP services, and sometimes professionals aren't aware of how to complain either. The review team was told that there is a particular issue in terms of the South Asian community being reluctant to complain about GPs. This was believed to be a result of these patients' particular loyalty to their GPs; at the same time there were instances where people had complained and as a result whole families had been struck off practice registers.

5. Good Practice Overview

- 5.1. The review team was consistently impressed by the **energy, enthusiasm and commitment** shown by the staff they met during their visit to BAtpCT, and their determination to address the challenge of diabetes within the South Asian community. BAtpCT staff consistently displayed willingness to learn, understand and be challenged.
- 5.2. Conversations with community members demonstrated an increasing level awareness and concern about diabetes as an issue - a tribute to the work that the PCT has been doing since Race for Health's appreciation visit to the Trust in February 2005.
- 5.3. It is clear that there has recently been **much closer working** between Race for Health/equalities and diversity staff and the diabetes/dietetics teams. This is a very positive development. Sharing of best practice has taken place in several forums:
 - A **Sharing Best Practice event** held in February 2006 looked at what had been done across all aspects of care that had had a positive impact on the South Asian community. The diabetes team invited participation from anyone across the four PCTs to learn from successful engagement approaches.
 - 'Multi-team' **brainstorming around the Diabetes Care Pathway** in 2005 drew on the knowledge of staff engaging with patients at each stage of the care pathway, as well as local religious and community leaders.
 - Similar **protected learning time events** run four times a year for practice nurses, and once a year these focus on diabetes. This covers new services and referral pathways, and this information is disseminated to practices without nurses by the nursing support team.
- 5.4. Staff know that change and improvement is required and they are eager to implement it. Although the recent merger of the four Bradford PCTs presents a major organisational challenge, many also see it as an opportunity. However, BAtpCT staff questioned where diabetes and health inequalities will fit among the priorities of new PCT, and whether previous levels of investment will remain. Some clinical staff spoke of a desire to "dig in their heels" to protect targeted work from dilution; although the proportion of BME people may have been reduced by the expansion of the

PCT's boundaries, staff emphasise that they are "still serving the same communities" as before.

- 5.5. Recruitment to the new PCT's board has left some unconvinced that Bradford City tPCT's emphasis on race equality has been transferred. Yet encouragingly, BAAtPCT's new leadership made a point during the review of emphasising its 'total' commitment to maintaining a strong organisational focus on the equalities agenda and ongoing support for innovative work around diabetes. The Chair of BAAtPCT remarked in his opening address that the future would be "not just about taking forward what the four PCTs were doing, but aiming above that". In line with this, the review team suggested that an assessment of where each of the four PCTs were with regard to equalities was needed to bank learning and spearhead new change.

Strand one: Prevention

- 5.6. The annual **Lifestyle Survey** is an excellent resource for the whole PCT, and BAAtPCT may wish to expand its scope.
- 5.7. BAAtPCT has piloted some **innovative approaches** to the prevention and management of diabetes – e.g. the programme of supermarket tours and the 'cook and eat' sessions.
- 5.8. Staff remain determined to **reach all sections of the community**. This has led, for example, to the increasing use of community venues for engagement work. Experience has shown that attendance is much better at these events.
- 5.9. BAAtPCT has successfully won funding from the Local Development Plan for a **community outreach worker**, who will develop a strategy for raising awareness of diabetes and its prevention. The post-holder's primary remit will be grassroots work and acting as a catalyst for better engagement with the voluntary sector.

Strand two: Culturally competent services (retinopathy)

- 5.10. The review team thought that Bradford's Retinopathy Screening Programme (RSP) was a **very robust** system - well-planned and thought out despite difficult circumstances. National recognition was given to Bradford's RSP at the recent national screening conference. It was commended for:
 - its robust recall system;

- managing to get four digital camera screening sites up and running in less than a year; and
 - the appointment of a dedicated project manager, who has been able to drive the project forward.
- 5.11. **Excellent progress** has been made toward the national retinal screening target: BAAtPCT screened 70% of diabetes patients in 2006, up from 50% in 2005. The move towards computerised systems will have helped with this, and should continue to improve the system's effectiveness for all concerned.
- 5.12. BAAtPCT staff have taken particular account of the needs of the Muslim community (e.g. around Ramadan). Clinic locations have also been planned to suit local populations.
- 5.13. The diabetes nursing team has made excellent inroads into local general practices, and has managed to keep **strong relationships** with optometrists despite the cut in income brought about by the shift to digital screening. This suggests regular and effective communication.
- 5.14. BAAtPCT staff acknowledge that there will be an unregistered population and particular groups that are not presently reached by the letter/telephone based RSP. However it does support **ongoing efforts to access transient and vulnerable populations** such as refugees and asylum seekers, homeless people and travellers – all of whom are proactively targeted by one innovative central city organisation, Bevan House. The PCT allows any health or allied professional to refer patients on to the RSP.
- 5.15. Translating and delivering the 'Xpert' structured education programme in **community languages** without removing its more complex elements is linguistically challenging and will delay its roll-out. However, despite the fact that it could readily meet the interim national target by delivering structured education in English, BAAtPCT is determined to deliver, from the start, a quality course that will be accessible to all of its South Asian patients.
- 5.16. BAAtPCT's delivery of the course to **health professionals** working with diabetes sufferers should help to ensure consistent messages are given to the patient.

Strand three: Evaluation and impact

5.17. BAtPCT has shown:

- **Recognition of the need to assess** the impact of individual initiatives and to create an 'evaluation culture' (e.g. current evaluation of RFH).
- Recognition of the need for **greater patient involvement**.
- **Imaginative and creative approaches**, particularly in terms of using Islamic culture to promote health messages: e.g. the use of 'prayer positions' to remember exercises and tie-ins with Ramadan radio.
- Commitment to maintaining a **ward/locality focused approach** within the expanded PCT, which can recognise the particular needs of different areas.
- Anecdotal evidence that lifestyle **messages are getting through** – e.g. more South Asian women are exercising in local parks.
- Recruitment of a local person with existing links into the community as a **health development worker**.

6. Recommendations

Consolidation

- 6.1. Bradford and Airedale's status as a Teaching PCT, its large South Asian community and the prevalence of diabetes in the district make for an appropriate **ongoing focus** for the merged PCT; the learning and effective practice it could generate could have a national ripple effect. The review team believes that more staff will 'step up to the plate' if the leadership and resources are forthcoming; a major push by the new PCT now could be a tipping point to achieve the 'transformational push that is needed'.
- 6.2. BAAtPCT must ensure that progress on race equality generally, and work on diabetes specifically, is **consolidated and extended** across the unified PCT. It should aim both for the expansion of effective targeted initiatives and the mainstreaming of race equality within the 'warp and weft' of its work.
- 6.3. The Equalities staff working within BAAtPCT should **consider the most effective area to focus their work**; currently their work has been primarily focused on influencing the provider arm of the PCT. However in the new structure of BAAtPCT, it should be considered if equalities work should target the commissioning activities of the PCT. Influencing the Service Level Agreements developed with the PCT's providers and practice based commissioning could result in the most significant service improvements for BME communities in Bradford.
- 6.4. **Links between activities** need to be clearer. There was sometimes a sense that the diabetes/dietetics work is peripheral or disconnected from other parts of the PCT, despite the scale of the challenge.
- 6.5. There is a need to embed within the new PCT what each of the four PCTs have learned from their previous work. More **formal mechanisms** should be established for the capture, analysis and dissemination of the local 'soft' intelligence that is available, both from within BAAtPCT and between the PCT and its partners (NHS, other mainstream providers, the local authority and the community and voluntary sector). The PCT should endeavour to capture staff's ideas as they emerge, even if implementation may not be immediate.

- 6.6. There is a need to **more clearly define the challenges** before solutions can be prioritised – e.g. is it poor access to services, lack of culturally appropriate services, staff attitudes, patient lifestyles, or other issues? The team believes that Race Equality Impact Assessments are a key tool for managing this process in a systematic way.

Engagement

- 6.7. More **proactive and regular engagement with patients**, their representatives and other community members will promote better understanding of their needs and concerns. This should take a variety of forms, from engagement events and expert patient groups to consistently seeking feedback from service users (in the latter case, as opposed to acting only on complaints/requests). The whole PCT needs to buy into the Public and Patient Involvement (PPI) agenda, working toward public and patient involvement in the design and commissioning of services.
- 6.8. BAAtPCT should consider expanding its use of **community development approaches** and recruit more people into its workforce from target communities. Expertise/experience can sometimes count for less than access (this also applies to working with the community and voluntary sector and with individual volunteers).
- 6.9. Engagement with specific groups is easier when there are formal structures set up or good links into a community (as is the case with the Pakistani community). However, the PCT must make sure it also **engages with other vulnerable communities** who may be less obvious or less vocal – for example, new arrivals from Eastern Europe.
- 6.10. BAAtPCT needs to routinely explore the **gender implications** of its prevention initiatives, especially in light of the public sector gender duty. The team were not convinced that this is happening at present.
- 6.11. The review team noted that many of the initiatives targeted at the South Asian community had focused on the family. However BAAtPCT also needs to target some **health promotion messages specifically at children**, as the area's large and expanding young South Asian population needs to hear appropriate messages on diabetes prevention. Interventions that focus on the wider family may not be as effective for this audience.

- 6.12. Use of **local media** to promote health messages – e.g. Ramadan Radio – appears to have been effective. More use should be made of the media in future.
- 6.13. The PCT should ensure that it **spreads awareness** of its services and programmes as widely and consistently as possible among those in contact with its patients, e.g. through allied health professionals such as pharmacists. BAAtPCT should also think more laterally about working in partnership with other local players to promote both healthy lifestyles and its services - e.g. Lloyds Pharmacy, Mumtaz restaurant and local schools – as well as establishing better relationships and greater involvement with key stakeholders, such as Diabetes UK and the National Diabetes Support Team.
- 6.14. Bradford benefits from a large number of GPs with special interests (20 GPSIs city-wide) who are looking at broader diabetes issues, prevention, and strategic development work. **GP champions** could be utilised much more regularly and strategically than at present. Staff also believe that there are a number of practice nurses who could become champions for the PCT's work around diabetes prevention and management.

Evaluation

- 6.15. Robust evaluation must be built in as a key feature of future work. In particular, appropriate evaluation techniques are required to measure the impact of BAAtPCT's various community engagement and health promotion initiatives.
- 6.16. The team urges BAAtPCT to keep the development of robust, systematic **patient profiling/ethnic monitoring** in primary care as a key work priority. This in itself will support a better understanding of how BAAtPCT's South Asian and other ethnic minority communities take up, experience and respond to services, thereby underpinning the majority of its race equality work. There is scope for more standardisation of referral forms across the PCT.
- 6.17. Commissioners need to ensure that provider agencies collect good quality data to **support the development of an evaluation culture**. A patient profiling requirement should be incorporated into all Service Level Agreements, and all PCT referral forms/patient records/IT systems should support the collection of this

information. Ongoing work to encourage and support patient profiling in general practice should be stepped up.

- 6.18. The team felt that the PCT's **health informatics** function would benefit from a health information strategy – it is not presently clear how this work maps against other data streams across the PCT or what the priorities are for analysis. The team heard that there is a lack of robust management information that could help teams to plan their services in future.
- 6.19. BAAtPCT needs to **triangulate all the information it currently collects** in a more systematic way. This would cover patient profiling/ethnic monitoring, collection of PALS feedback, data about the take-up of services and the formal collection of qualitative information which is currently described as 'anecdotal'. The use of a **variety of evaluation approaches** to qualitatively describe the patient experience would be needed to support this, for example more use of focus groups (NB: the review team's experience with the South Asian women's group at the Khidmat Centre suggests there is much to be gained from this method). This information could then be used in conjunction with data from more formal evaluations, to develop a comprehensive picture of service use and the patient experience.
- 6.20. BAAtPCT should also conduct a survey to collect **evidence of positive behavioural change** among its target populations and learn the reasons for these changes. Specifically, have they come about as a result of Bradford's health promotion work, or from wider shifts in society linked to either national campaigns or cultural change? A good place to start would be seeking feedback from those who have already participated in/benefited from BAAtPCT or partners' interventions.
- 6.21. There is a clear need for more '**cross-mapping**' of all data to build a picture of poor up-take across service areas (e.g. retinopathy and cervical screening). This could identify whether specific communities are consistently affected and lead to a more cost-effective, multi-pronged effort to boost up-take.
- 6.22. The mechanisms which link the findings from data collection and analysis and local intelligence to the **commissioning** process will require further strengthening. The team were not convinced that commissioning is making best use of the information that does exist.

- 6.23. BAAtPCT has shown that it is willing and able to work with partners to engage with specific communities and to deliver more targeted services. However, the team recommends that it draws up a **model for future working with partners**, accompanied by a prioritisation plan, to establish where the PCT needs its own initiatives and where it can work with/through others to meet its objectives. For example, the diabetes/dietetics teams should revisit their action plan in light of emerging agendas – there may be a tie-in with Local Area Agreements.
- 6.24. Where the PCT does wish to work with partners to deliver an initiative, it should ensure it is aware of any **pre-existing evaluation activity**, or institute its own.

Strand one: Prevention

- 6.25. At their host's request, members of the review team discussed the supermarket tours project and came up with several suggestions for how it could be targeted more effectively, some of which have more general implications for BAAtPCT.
- 6.26. The review team thought that BAAtPCT should reflect on whether the measures taken to increase participation in this initiative would have enough impact to make the efforts worthwhile – but if so, staff should consider:
- Whether the supermarket is seen in any way or circumstances as a male territory – and possibly look at having male and female workers there to run different tours;
 - Taking just two or three people on the tour and engaging others who are in the supermarket in the discussions at the same time;
 - Linking the initiative in with activities that are already working well, such as the 'cook and eat' sessions;
 - Literacy levels – it may have been that members of the South Asian community could not read the leaflets that were used to promote the tours;
 - Exploring others way of getting the messages out – East Berkshire PCT have, for example, used a health bus with a particular focus on diabetes;
 - Using incentives – the project could possibly offer free produce as a way of getting people on board;

- Branding and social marketing – using owners of local restaurants (such as Mumtaz) as well as the Asian supermarkets to brand products in a way that makes them fashionable to buy and raises the profile of healthy eating;
- Exploring opportunities to utilise community and voluntary organisations – the PCT is already working on an ad hoc basis to provide services through community organisations, but this could be stepped up; and
- Linking with educational institutions to educate young people, particularly madrassas (Islamic schools).

Strand two: Culturally competent services (retinopathy)

6.27. The Retinopathy Screening Programme (RSP) should:

- Consider extending its hours for booking appointments (e.g. including an evening or Saturday morning) to ensure better access.
- Explore translating written communications/patient information from the RSP into community languages.
- Consider for wider roll-out the policy of phoning to confirm appointments where a patient has failed to attend previously and using bilingual staff to do this, in case literacy issues are a factor. This has already been voluntarily adopted by some clinics conducting retinopathy screening. The current policy of sending letters to GP's of patients who did not attend their appointments relies on GP's actively following up these letters, and this not maybe the most effective way of engaging South Asian Communities who suffer from multiple levels of deprivation.
- Be proactive in making patients aware that female screeners are available, and during Ramadan, that eyedrops will be administered as part of the screening. An absence of complaints or requests should not be taken to mean that patients wouldn't welcome this information in advance.
- Undertake an Equality Impact Assessment on the shift to digital camera screening, to explore how different ethnic and religious groups may be affected. The team also heard that some disabled people (specifically wheelchair users) could be excluded by the new technology; this could have legal implications for BAtpCT and should be addressed.

APPENDIX ONE

The Peer Review Team

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APPENDIX TWO

BAtPCT participants

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APPENDIX THREE

The peer review process

Peer Review visits are an opportunity for the host PCT to demonstrate their progress on one area of the programme that they are seeking to develop and to gain constructive challenge and advice from visiting PCTs.

Peer review is widely used as a performance improvement tool within government departments, local government, academia and the business world. It employs a cooperative, participatory and high-level approach that tends to be viewed more favourably by the host organisation than a formal inspection. Peer reviewers are 'critical friends', not inspectors. The review is owned by the organisation and the focus is constructive.

Peer review is conducted intensively over a short period of time, but peers are nonetheless able to offer a useful and independent assessment. The team is ideally made up of knowledgeable people working both at a senior and operational level within the sector, including those who understand the community perspective. This enables them to 'hit the ground running'; as they already understand the complexities of the operating environment and the strategic challenges facing PCTs.