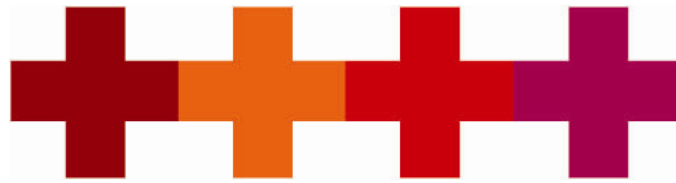


race for health



a transformational change programme

Bristol PCT Peer Review

24th/25th January 2007

Outcome paper

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Executive Summary

1. Bristol PCT's peer review took place on 24th and 25th January 2007. This paper sets out the review team's finding and recommendations. It is drawn from presentations and discussions during the visit and provides a set of 'informed reflections'.

Theme and key questions

2. The review focused on the customer service experience of Black and Minority Ethnic people (BME), and NHS organisations' response to their concerns. The peer review explored the following:
 - How effective are Bristol NHS organisations at currently responding to complaints by **BME patients**?
 - How do Bristol NHS organisations currently understand and respond to **BME community concerns** at the service interface, executive and middle management levels?
 - How does Bristol Primary Care Trust take account of the concerns of **BME communities** in the commissioning process?
 - How effective will the proposed new service be at improving service delivery for **BME communities**?

Overview

3. Bristol Primary Care Trust (PCT) was established on 1st October 2006 following the merger of Bristol North and Bristol South and West PCTs. The Bristol Race Equality Health Partnership (BREHP), an external partnership, acts as the main forum to bring together NHS partners from the local health community and representatives from BME community organisations. It has carried out several key areas of work since its formation in 2002.
4. Over the past year community representatives on BREHP have expressed frustration about incidents of poor health services experienced by their communities, who are reluctant to make them known directly to staff in the NHS. NHS organisations, in turn, were also frustrated as they required more concrete information in order to initiate an organisational response. The need to get a richer seam of evidence has led to a new pilot project commissioned by BREHP. Community groups and frontline staff will be asked to capture these informal customer service experiences and feed them back into the PCT.

Strengths

5. Bristol PCT's leadership demonstrates strong vision and direction and is committed to ensuring that equality and diversity is integral to the PCT's core business. The PCT is not afraid to experiment and has shown a willingness to look at short-comings, and work with its NHS partners to better respond to community concerns.
6. There is a strong desire to develop services which meet and respond to need, and the review team heard about specific examples of good practice which illustrate this aspiration. Consultation and involvement has become part of the PCT's mainstream activity, and BREHP is a unique partnership with a longstanding tradition of engagement. Communities valued the PCT's willingness to listen and welcomed the idea of the new

customer service project. Enthusiastic PALS staff in the PCT and two hospital trusts are also beginning to work together towards a fully integrated service.

Areas for development

7. Some areas which need further development include:
 - Linkages between different departments and between different parts of the PCT, for example frontline staff, managers and commissioners, needs to be strengthened.
 - The new project should not be seen as a stand-alone initiative or a magic bullet that will deal with all BME issues and concerns. It brings with it an opportunity to review how the PCT collects and responds to (BME) patient concerns on an organisation-wide scale.
 - PALS needs to be reviewed alongside the new project and could be developed more distinctively as the main patient feedback mechanism.
 - Bristol PCT has invested in collection and use of data and information. More emphasis, however, should be given to the value of 'soft' qualitative information and collecting this information systematically to inform commissioning decisions.

Recommendations

8. Many of the recommendations focus on improved communication and information – both internally and externally. They include:
 - An organisational message about race equality should be sent out more strongly by the PCT, utilising its strong non-executive team champions.
 - Review/reconfigure PALS alongside the new project.
 - Learn from the new project and develop more robust systems to capture, monitor and respond to patient concerns, and to feedback to communities and to BREHP.
 - Stipulate, in SLA requirements, how information on the patient experience has been gathered and used to improve services.
 - Develop more effective use of PALS intelligence in all commissioning.
 - Empower staff to be part of the change process and encourage them to feedback patient/user concerns and develop ideas and solutions.
 - Culturally competent care: NHS organisations should 'go back to basics' particularly at the user/patient first point of contact with services.

1. Introduction and theme for the review

- 1.1. Bristol Primary Care Trust (PCT) hosted a peer review on 24th and 25th January 2007. The visiting team included peers from other Race for Health PCTs across the country, the national Director of Race for Health, and learning programme co-ordinators from Shared Intelligence (see Appendix 1).
- 1.2. The review team received an overview from Bristol PCT senior staff and from a non-executive director as chair of the Bristol Race Equality Health Partnership (BREHP). The team also spoke with PCT staff from finance, commissioning, corporate services and primary care; NHS partners; Patient and Public Involvement (PPI) and Patient Advice and Liaison Service (PALS) managers; staff working directly with Black and Minority Ethnic (BME) communities; health link workers; and representatives from community groups (see Appendix 2)
- 1.3. The peer review is a constructive and mutually supportive process that helps PCTs to look at how they are performing in a specific area, its strengths and the areas for development (see Appendix 3). This paper sets out the review team's findings and recommendations based on presentations and discussions during the visit and informed by background documents. It provides 'informed reflections' on the work of Bristol PCT and other Bristol NHS organisations in relation to the customer experience of Black and Minority Ethnic people and on health services' responses to user and patient concerns.

Focus of the peer review

- 1.4. The review focused on the customer service experience of Black and Minority Ethnic (BME) people, looking at how existing services/processes currently respond to patient concerns, and also to comment on the development and design of a new customer service project. The peer review aimed to explore the following questions:
 - How effective are Bristol NHS organisations currently at responding to complaints by **BME patients**?
 - How do Bristol NHS organisations currently understand and respond to **BME community concerns** at the service interface, executive and middle management levels?
 - How does Bristol Primary Care Trust take account of the concerns of **BME communities** in the commissioning process?
 - How effective will the proposed new service be at improving service delivery for **BME communities**?

2. Background and context

About Bristol

- 2.1. Bristol is an historic city and port, and is now the largest city in the south west of England, with a population of approximately half a million. The city has two universities, two teaching hospitals and a wealth of parks and green spaces. It also hosts the British and Commonwealth Museum, providing a celebration of the contribution of people, countries and migration to contemporary Britain.
- 2.2. The main tourist and city centre is focused around the Bristol Docks, Cathedral and Council House (central and west), with an outer ring of post war housing estates around the perimeter. The main shopping centre (central and east) is currently being rebuilt. The majority (but by no means all) of Bristol's BME communities live in and around the inner city areas (central and east), which straddle the end of the M32 city access road.
- 2.3. Bristol's wealth and historic past bring with it the legacy of the transatlantic slave trade. This is an issue which is still painful today with debate about the need for a public apology from the city for the part it played in the slave trade. Bristol is a vibrant city, but one with extremes of wealth and poverty and a rich and complex history, which provide the canvas for modern day civic life.

Population

- 2.4. The city of Bristol is made up of 35 electoral wards with a mid year population estimate of 398,000 (Bristol City Council 2005). This figure adjusts for a significant undercounting of the population, which was identified after the 2001 census particularly in three wards of Easton, Ashley and Lawrence Hill. These wards have the highest numbers of BME residents.

Ethnicity

- 2.5. Bristol has a long history of immigration and its BME population is growing steadily; between 2001 and 2005, the percentage of the population from BME groups increased from 9.2 to 10.5. Increases have been in the Asian/Asian British communities (particularly Indian), Black African communities (particularly Somali) and 'white other' (particularly eastern Europeans, the majority Polish).
- 2.6. As well as the acknowledged undercount during the 2001 census, the PCT is aware that many BME residents did not participate in the census count and that migration and informal residency means that these figures are almost certainly lower than the actual resident population.

Bristol Area NHS community

- 2.7. The City of Bristol has two large acute Trusts – United Bristol Healthcare Trust (UBHT) and North Bristol Trust (NBT) – who between them manage a number of hospitals and hospital departments. In addition, the mental health trust, the Avon and Wiltshire Partnership, covers a large geographical area that is organised in divisions and of which Bristol is one. Ambulance services for the population are provided by the Great Western Ambulance Service. The Bristol Health Services Plan is an overarching plan for the city that aims to reduce reliance on acute care by moving more services into community health care centres and to develop and modernise buildings and services in both the acute and primary care sectors.

Bristol Primary Care Trust

- 2.8. Bristol Primary Care Trust (PCT) was established on 1st October 2006 following the merger of Bristol North PCT and Bristol South and West PCTs. The PCT's responsibilities include assessing the health needs of its population and commissioning services to meet those needs, with the majority of Bristol's acute services being commissioned from the United Bristol Healthcare Trust and North Bristol Trust. The PCT is also responsible for providing most of its own community health services and for supporting the development of primary care (general practice, dentistry, pharmacy and optometry). Bristol PCT has 58 GP practices with a GP registered population of around 450,000.
- 2.9. The boundary for the PCT has been coterminous with Bristol City Council since October 2006 and the PCT works closely with the City Council and local voluntary sector partners on issues relating to and affecting the health of the people of Bristol. The new Director of Public Health is therefore a joint appointment between the PCT and Bristol City Council.
- 2.10. The Bristol PCT Race Equality Scheme and Action Plan (2005 – 2008), published in November 2006, incorporated Schemes from the previous PCTs. The PCT publishes annual progress reports on these Schemes and gives feedback at an annual community and stakeholder conference. The PCT has also completed a number of Equality Impact Assessments (all include a Race Equality Impact Assessment) and developed a forward programme. The Health Care Commission recognised Bristol PCT as one of very few NHS organisations in the country as compliant - with access to information through their published RES, employment figures and Equality Impact Assessments.

3. Tackling race inequalities in Bristol – our findings

- 3.1. This section outlines some of the findings from the peer review, and is drawn from documents, presentations and five focus groups with commissioners, PPI and PALS staff, NHS partners, Black and minority ethnic (BME) community groups and front-line staff working directly with BME communities

Commitment to Race Equality

- 3.2. Bristol PCTs have demonstrated their leadership and commitment to race equality over a number of years. This strong vision, direction and enthusiasm now runs through senior levels in the Board and staff of the new organisation. The new chair's vision is to develop a customer ethos with a responsive NHS treating people *"as if they have a choice"*. This is even more important for BME communities, and when it happens *"BME communities will be really empowered"*.

Establishing responsive structures and systems

- 3.3. Bristol PCT's race equality work is managed through a number of strategic partnerships and forums. Two of the main ones are the Bristol PCT Equality Strategy Group, an internal committee which focuses on the overview, scrutiny and performance management of the PCT's equality duties, and the Bristol Race Equality Health Partnership (BREHP), an external partnership which provides a forum to work with NHS partners from the local health community and representatives from BME community organisations.

Bristol PCT Equality Strategy Group

- 3.4. The Bristol PCT Equality Strategy Group is responsible for ensuring the promotion of race equality in the Trust's employment, service commissioning and service providing functions. It is also responsible for the Trust's duties in complying with the standards required in the Race Relations Amendment Act 2000. The chairperson is a non-executive Director of the Trust board and the group reports through the PCT's governance committee to the Board. Membership consists of representatives from across the PCT to reflect its functions as an employer, commissioner and provider of health services, as well as representatives from community and voluntary sector organisations to foster race equality in health service commissioning and providing functions.

Bristol Race Equality Health Partnership

- 3.5. Bristol PCTs have long recognised the need to involve all NHS partners in improving services for BME communities. The Bristol Race Equality Health Partnership (BREHP) acts as the main forum for bringing together the family of Bristol NHS organisations with the council, voluntary organisations and community

representatives to focus on BME issues and work together on solutions. This umbrella group has improved relationships across the NHS and encouraged a more creative working environment. BREHP has carried out several key areas of work since its formation in 2002. These include developing translation and interpreting services; cultural competency training, with community members delivering the training; employment outreach, raising the profile of careers in the NHS with BME communities; influencing options in hospital food; and research into diabetes, heart disease and stroke prevention.

- 3.6. Recently, however, the way that BREHP works has changed. The reasons include the need to find more effective ways of working together in response to some pressing issues brought to BREHP by the community representatives on the partnership. BREHP now meets in two parts. The statutory partners work together as the key forum for ensuring a joint approach to tackling race equality, and the community organisations do the same – then coming together to operate as a more strategic body.
- 3.7. Over the past year, community representatives have expressed frustration that they receive, through their communities, stories and complaints about poor service in relation to race equality issues. NHS representatives on the BREHP have also felt frustrated, as they can only initiate organisational responses to these complaints on the basis of concrete evidence.
- 3.8. On the one hand, it was clear that existing policies and procedures were not giving community organisations confidence that individual cases were being dealt with effectively. On the other hand, there was insufficient detail for the problems to be pursued, for example many reports did not necessarily differentiate between NHS organisations. It was difficult for BREHP to deal with these individual situations and to get to the bottom of the effectiveness of Bristol's NHS organisations in understanding and responding to needs of BME communities; as well as effectiveness of their systems for responding to informal concerns and complaints.
- 3.9. The difficulty was that although individuals share these experiences within their community, they are reluctant to make this known to staff or to the organisation (s). However without evidence, the organisation does formally not know that there is a problem. The outstanding need to get a richer seam of evidence has led to the new pilot project.

New customer service project

- 3.10. A new piece of work, commissioned by BREHP, attempts to capture informal experiences and feed them into the NHS performance management and governance systems. A simple system for recording these informal customer service experiences is being developed which can be used by community groups and front line community staff, such as health link workers, project

staff and care assistants, and which will build up a picture of BME customer service experiences. Organisations and/or individuals have been invited to tender to develop the work through a 12 month pilot.

- 3.11. It was acknowledged during the peer review visit that in spite of good progress over the years, the challenge is now *“how much race equality has been mainstreamed and permeates the core business of NHS organisations in Bristol”*. The new project provides an opportunity to strengthen the response of NHS organisations to BME communities’ issues and concerns.
- 3.12. The project was described as an attempt to respond to what BME communities are saying in a way that delivers real action and change, and that maximises opportunities for effective patient and public involvement. The PCT would also like to use the project to explore other creative ways of achieving BME customer service feedback.
- 3.13. The review team heard that the idea of this new initiative is welcomed - *“the concept is good”*. Community representatives think the intentions of the process are positive, and they want to be kept actively involved in order to have the confidence to sell it to their communities and encourage them to use the process. Some of their concerns focus around what will happen to the information, how seriously trends will be looked at, demonstrating how problems have been tackled, and sustainability. These will need to be addressed as the project gets off the ground.

PPI and PALS: existing ways of responding to concerns and complaints

- 3.14. *Patient and public involvement* is integral to the PCT’s internal planning system and to their external activity. One example is the engagement of BME communities with proposals in the Bristol Health Services Plan. The Plan proposes reducing acute units and providing support with community hospitals and other community services. The PCT found it difficult to consult and engage communities, particularly BME communities, in this plan’s proposals. A workshop was held with community groups to test out the best ways to engage different communities. Community groups were resourced and supported by the PCT to make the contact with communities and over 500 people were then engaged in the process.
- 3.15. The *Patients’ Forum* is small with 12 active members. Managers attend regularly and report back to the forum. The forum has also been out to GP services to ask about their complaints procedures. The *formal complaints service* deals with around 60 complaints a year although complainants are encouraged to resolve issues informally in the first instance.
- 3.16. The PCT’s *PALS* team has the equivalent of two full time staff and the service deals with around 550 cases each year. The telephone service is well-used and an assessment is carried out

on all people who attend their office base. The peer review team felt that the PALS' caseload appears small in relation to some other PCTs but the people they are in contact with receive a high level of input, for example PALS staff visit bereaved people and act like informal counsellors. This was perceived to differ from common practice amongst PALS elsewhere.

- 3.17. PALS' capacity is an issue in the PCT. The challenge is how much to publicise the service and then potentially generate more work with limited resources. PALS staff would like to get out more into communities but face the tension between running face-to-face/telephone advocacy work and community based outreach on limited resources. PALS staff fully supported the development of the *new customer service project*. Whilst having some understandable misgivings about the large number of issues/individuals which may require support as a result of the new project, they recognise that it will indicate need within communities and generate learning for their service.
- 3.18. Although a lot of effort has been put into engaging with BME communities, they appear reluctant to use the existing PALS system and be seen to 'make a fuss'. The review team heard that while communities recognise the importance of this service and its potential to respond to community concerns, there is some confusion. This appears to focus around:
- lack of awareness and understanding of what the service provides and can offer
 - fear of what will happen to the information and how it will be used
 - fear of how they will be subsequently treated
 - perception that the service is not independent from the trusts.
- 3.19. Bristol *acute trusts* have produced their own PPI strategies. Individual directorates of UBHT have their own service user groups, community engagement, PPI leads, PALS and complaints systems. Acute sector partners want to continue to improve their own services and the way they use information from PALS and other sources. They recognise that one way forward is for frontline staff to feedback and work together with senior managers in both trusts to improve customer services. Staff act as a first contact with patients and are able to identify where services can be improved. PALS staff from across both acute and primary care sectors meet regularly to ensure co-ordination, including on the equality agenda which is becoming more of a focus in the acute trusts. For example UBHT has a race and faith group.
- 3.20. The aim in Bristol is to see a fully integrated Patient Advice and Liaison Service. There is enthusiasm about the two PALS teams from the previous PCTs moving to one service and a desire to build on the existing good practice between all PALS teams across the NHS. Joint visits have already taken place for example to GP practices. New leaflets have been produced in different

formats and languages to go into all primary care services. The review team also thought that a widespread promotion of PALS across different voluntary and community sector groups would improve community awareness of the service. The review team heard that there is also scope for more joint working between PCT and acute trusts in resolving commonly raised issues.

- 3.21. PALS staff have developed a clear picture of changes that would improve the service and have produced an action plan. Areas for improvement highlighted to the review team include better communication about the service, reporting back to the wider community, and reaching out more effectively. It is recognised that much of this will be achieved by sharing resources and being more organised.
- 3.22. In the PCT there are clear avenues from PALS into the organisation. PALS' reports go to the governance committee (a sub-group of the Board) and are then fed through to the Board. If a specific issue arises these reports are shown to the relevant director who may then share them with front-line staff. The review team was impressed by the way in which the PCT has sought to triangulate complaints, PALS, and incidents data into a combined report. The PCT recognises, however, that more could be done to learn from issues and complaints, identify recommendations for improvement from the patient perspective, and to feedback to communities.

New ways of communicating with BME communities

- 3.23. The Race Equality Scheme Manager, on a one year secondment to the PCT, has developed *web pages* on the PCT website to communicate equality and diversity matters to the public, staff and board members (see www.bristolpct.nhs.uk/theTrust/Equality/default.asp). The web pages raise the profile of the work and also act as a 'one stop shop' for commitments, performance and guidance. He has also produced the first equality update *bulletin*. This is aimed at BME voluntary and community groups and key front line NHS staff. The bulletin will inform them about progress on Equality Impact Assessments, direct people to relevant information, and invite them to comment on particular issues. It is published by the five NHS partners who are members of BREHP and will be distributed by direct mailing and via the website.

Developing responsive services

Consultation and engagement

- 3.24. The review team was impressed by the culture in the PCT of consistent consultation as part of mainstream activity. This was reinforced by community representatives who recognised that the PCT is trying to listen and respond more effectively. Community groups also value the opportunities provided by the annual

BREHP event and workshops which reach out to more groups and individuals.

- 3.25. Within the context of considerable efforts to consult and involve communities about delivery of services and responsiveness to their needs, a number of concerns were raised about the breadth of engagement. Consultations are *“not always getting to the grassroots”* and community members highlighted some difficulties when NHS organisations use intermediaries. The PCT has also responded by asking community groups themselves to reach out into their communities. While this is welcomed, groups feel there is sometimes too much expectation in terms of the role they will play. Continuing the dialogue with communities about the best ways to broaden engagement and the support required would reinforce that this is a shared endeavour.

Commissioning process

- 3.26. The commissioning process hinges around the priorities identified in the Local Development Plan. This three-year plan is reviewed every year. The fitness for purpose development plan also informs commissioning decisions.
- 3.27. Commissioners are committed to race equality. They are keen to commission appropriate services and to develop services which meet and respond to need. Commissioners consult with a range of groups. They hear views from a health interest group that consists of lay people who have an interest in health issues. However, equality and race issues only appear to get onto the agenda of the health interest group if raised by the PCT. It may be useful for the lead for Equality and Diversity to sit on this group or provide some input. Commissioning staff also identified the need to ‘go out more’ and engage and consult with newly arrived communities, particularly from Poland and Eastern Europe.
- 3.28. The review team thought that the commissioning process could benefit from gathering patient feedback as part of the performance information required from providers. This would help inform quality commissioning decisions. Currently, however, commissioners do not appear to request such data from their providers.
- 3.29. The PCT, including the Board, has good relationships with many parts of the voluntary sector. There is a desire on the part of commissioners to develop this relationship and support the voluntary sector more effectively to enable them to become prospective providers. This would build on earlier PCT workshops aimed at engaging voluntary and community groups more in the commissioning process.

Use of data and intelligence

- 3.30. Public health collects a wealth of information about different communities, particular trends and health needs. Information

includes both statistical quantitative data and softer, more qualitative information from individuals and front-line staff. This information has been used for Equality Impact Assessments and health equity audits as well as focusing on health needs of different communities and geographical areas.

- 3.31. Commissioning staff often find it hard to access information quickly, particularly soft information which can help them to respond promptly to changing needs of the population. In the revised public health structure there will be stronger links between commissioning and public health. A new post of Deputy Director of Public Health will have responsibility for increasing the amount of public health data which informs commissioning decisions. The Deputy Director will be responsible for heading up a team of public health analysts, consultants and researchers. This should create better integration between public health and commissioners.
- 3.32. The two acute trusts record the ethnicity of their patients. United Bristol Health Care Trust (UBHT) records 82%, and North Bristol Trust (NBT) 95%, and they plan to improve this. They are working with individual departments to increase ethnic monitoring and to help staff understand the reasons for collecting this data. Primary care has also completed an ethnic monitoring pilot which identified a high level of monitoring in GP practices in inner city areas, although they recognise that there is more to be done across the city.

Service/project examples

- 3.33. Front-line staff working with BME communities, community representatives and commissioning staff highlighted some examples of the way that services are specifically responding to BME health needs.
- Sickle cell and thalassaemia service*
- 3.34. As a result of concerns raised by patients and carers using the service, a dedicated post was created to support people with sickle cell and thalassaemia. This post has provided patients, relatives and carers with culturally specific support, guidance and a way to channel experiences and views to the PCT and acute trust.
- 3.35. In response to concerns raised by patients when using Accident and Emergency (A&E) in a crisis, two dedicated beds have been allocated on a ward. This enables a more sensitive and responsive service for people at a critical stage with their condition. Young people can access a similar service 9-5 on weekdays, but use A&E out of hours. ID cards with a traffic light system have now been developed for sickle cell and thalassaemia carriers which can be shown to NHS staff at any location and this avoids further screening. The idea came from people themselves who were unhappy about continually being re-tested.

- New Deal for Communities project*
- 3.36. This project is funded by Bristol's New Deal for Communities programme. The project is managed and developed at a clinician (health visitor) level, with the health visitor post funded by New Deal but employed by the PCT. The project uses interpreters to increase BME access to health services, identifies barriers and gaps and looks at reducing racism. Equalities meetings now take place at the local level with GP practice managers. A New Deal health regeneration specialist links into BREHP and public health, but the communication into the PCT about issues arising from this particular project appear tenuous.
- User Focused Monitoring*
- 3.37. Mental health service users are involved in evaluating mental health services, and this process is beginning to bring about change in the way services are delivered. Mental health service users wanted increased early intervention services in primary care as opposed to more acute hospital services and this is beginning to result in service change. It is hard, however, to show specifically how the views of BME service users have resulted in direct service change.
- Diabetes project for the South Asian community*
- 3.38. Two south Asian women were recruited as peer facilitators to deliver a culturally appropriate health education programme around diabetes.
- Translation and interpreting services*
- 3.39. Translation and interpreting services have evolved in Bristol over many years and have seen significant improvement. The health link workers' project enhances the standard translation and interpreting services and enables a more sensitive response and earlier interventions.
- 3.40. Access to interpreting services was, however, also highlighted as an issue. Currently there appears to be less provision in some of the main languages for which interpreters are requested - Polish, Somali, Eritrean, and Congolese. The route by which frontline staff flag up this problem was unclear and the review team did not get a sense of any response from the PCT in terms of resolving this specific operational issue. Examples were given of patients not knowing what medicine had been prescribed, what it was for or how to use it. Providing money for good translation services was seen as essential for improving access to health services for BME communities and especially for new arrivals. The limited resource also brings with it the difficulties of family members being used in place of professional interpreters.

Responding to needs of asylum seekers and refugees

- The Haven*
- 3.41. The Haven is a gateway PCT funded primary healthcare service for newly arrived asylum seekers and links into primary care and

education. Many new arrivals are not registered with a GP and do not have information about how to register. The Haven provides training for receptionists to deal with this issue. Although staff appear to be well-networked, reporting to stakeholders, Refugee Action, Public Health, Social Services, and South Gloucester PCT, this service would like to improve strategic links and communication back into the PCT about its work.

The review team heard about the main issues for asylum seekers and refugees:

- Workloads of school nurses have increased significantly to meet the *needs of refugee children* and 'new to country' children. These are children that have left their home country as a refugee and have come to the UK via another European country
- Post traumatic stress: only the tip of the iceberg is seen by the mental health trust. This difficult issue is exacerbated with non-English speaking refugees
- Lack of information about (access to) health services: registration with GPs and inappropriate use of A&E
- Maternity services have had to expand rapidly to meet demand.
- Many health professionals are unclear what type of health services can be provided to asylum seekers and refugees and failed asylum seekers.
- Resources need to be put in at the front end to avoid medium to long-term costs.

3.42. The *acute sector* is very aware that the population is changing and that NHS organisations need to listen and develop services to respond to needs of (new) communities. Specific issues, however, have arisen around Choose and Book and length of time for the booking process. Problems with communication and language barriers were exacerbating the problems for asylum seekers and those responding to their needs. This was made more acute by a lack of interpreters and additional resources were needed to address language issues.

Customer service/culturally competent care

3.43. The review team were given specific examples about how Black and minority ethnic people often perceive themselves to be treated by the NHS. "People are not treated with respect". This relates to values, attitudes and behaviour of staff. There is a case for NHS organisations going back to basics and improving customer care and customer service. This relates to how everyone is treated not only BME people. It revolves around people being treated as individuals without stereotyping and the NHS listening more to its users/patients.

4. Summary of strengths and areas for development

- 4.1. The following section summarises Bristol PCT's strengths and some of the challenges as identified by the review team during their visit.

Strengths

A visionary well-led organisation

- 4.2. The review team was impressed by Bristol PCT's strong vision and direction, as well as their clear leadership and commitment on race equality matters. This was evident at Board level from the Chair and non-executive team, together with an enthusiastic Chief Executive who is clear about equality and diversity being integral to the PCT's core business and wishing to move forward on the race equality agenda in the new organisation. This commitment was reinforced by other people during the visit who also commented on good and exceptional individuals in the PCT and other NHS organisations in Bristol.

One organisation

- 4.3. Despite massive changes, Bristol PCT has quickly moved to a single organisation and appears to be working as a reasonably coherent unit. The review team was particularly impressed by the enthusiasm of PALS staff, and the desire to work closer together across PALS in the PCT and two hospital trusts.

A brave and open organisation

- 4.4. Bristol PCT is not afraid to experiment. It has demonstrated a willingness to look at current practice, admit short-comings, and then develop ideas to overcome these and change the way they work. This is particularly evident in recognising difficulties in systems for responding to community issues, the concern to find solutions such as developing the pilot project, and changing the way that BREHP operates. The programme for the peer review visit also reinforced the PCT's openness in looking at these issues with peers from other PCTs and with their NHS partners.

A responsive organisation

- 4.5. The peer review team recognised the PCT's efforts to embed consistent consultation as a mainstream activity and to see it as a main plank of the commissioning process. There is a strong aspiration to develop services in response to need and a desire for frontline staff, as well as communities, to feed information into the system. Communities valued the PCT's willingness to listen and to encourage their views via regular workshops and conferences. BREHP is a unique partnership of NHS, and other public sector organisations, with voluntary and community groups. There is a strong and longstanding tradition of engagement within

BREHP, and examples of activities and change in response to community views, needs and priorities.

Examples of good practice

- 4.6. The review team flagged up several specific examples of good practice:
- Sickle Cell and Thalassaemia service with dedicated support worker, allocated beds, and ID 'traffic light' cards
 - Translation and interpreting services which have evolved and significantly improved over 20 years. This includes development of health link workers scheme which enables earlier interventions and better access to services
 - User-focused monitoring in mental health, with service users involved in monitoring and evaluating services, leading to change
 - Dedicated (race) equality and diversity web pages on PCT website with clear information and commitments to race equality
 - High levels of ethnic monitoring in GP practices in inner city areas and in acute trusts
 - Use of Equality Impact Assessments (EIA) with action plans for improvement which are discussed with BME communities

Areas for development

- 4.7. There are some areas where the review team identified challenges or where questions remained.

Communication and linkages

- 4.8. In spite of the strong commitment to race equality and desire for this to permeate all areas of the organisation, there does not appear to be an overview of the way things are currently working across the organisation (and between organisations), or where some of the blockages may lie. Hearts and minds seem to have been won, but there is still some uncertainty about how to action issues, create change and make a difference.
- 4.9. Linkages between different departments and between different parts of the organisation, for example, frontline staff, managers and commissioners needs to be strengthened. People should be encouraged to be active in making these links. Individual working relationships can often be enhanced through project work, away days etc. The review team felt that continuing to strengthen the relationship between public health and commissioners is particularly important and ways need to be found to feed information more quickly into the commissioning process.
- 4.10. Some front-line staff, particularly those providing specific community services, often feel divorced from the rest of the

organisation and two-way communication needs to be strengthened. The PCT leadership, and commissioners in particular, could also go out more into NHS organisations and communities to promote their vision, promote the new pilot project, and hear directly from staff and service users.

Listening to and responding to community concerns

New customer service project

- 4.11. The idea of the new project was generally welcomed across NHS organisations and community groups. There is evidence that anonymised information collected systematically can be used effectively. For example, hate crime is reported in such a way that anonymity is protected. Collecting the communities' concerns and 'complaint' information in an informal way should also increase response rates.
- 4.12. The new project is small-scale, but a lot of effort has gone into it, outweighing its actual financial cost. It will be important, however, that the project is not seen as a 'magic bullet' that will deal with all BME issues or concerns. The review team thought that there may be a risk that the project is not resourced well enough to meet the high expectations the PCT has invested and placed upon it.
- 4.13. It should not be seen as a 'stand-alone' initiative and brings with it an opportunity to review how the PCT collects and responds to (BME) patient concerns on an organisation-wide scale. For example, information gathered by front-line staff does not always find its way back to the PCT or other NHS organisations. Although front-line workers hear community concerns they do not appear to be linked well enough into the organisations to be clear how to pass on these comments. The project will provide the setting for front line staff to be more actively involved in reporting through the new system and responding to patient comments and concerns. BME staff forums were not considered as well-used as they could be as an intelligence mechanism. These matters need to be addressed as part of the PCT's new way of listening to BME communities.

PALS

- 4.14. PALS needs to be reviewed alongside the new project and could be developed more distinctively as the main patient feedback mechanism. PALS is primarily seen as a complaints service and communities are not generally aware of the support it can offer. The service could benefit from renewed communication strategies, better promotion using a number of avenues including front-line staff to promote its services, and being seen as 'independent' from NHS organisations.
- 4.15. PALS evidence and incident/complaints should be used to influence commissioning and this needs to include patient experience from new project. Another suggestion may be for PALS to provide a less intensive service, for example no bereavement home visits, which would free up time to see more

people and reach out into communities. The PCT could also consider targeting their next PALS vacancy at BME communities. PALS may need more capacity if the new project is successful and this will need to be identified and resourced appropriately.

Community engagement and feedback

- 4.16. BREHP appears to be viewed as the symbolic engagement process. As BREHP becomes more strategic, it will need to continue to evaluate its own effectiveness, particularly the breadth of engagement with communities and its accessibility. Communities value the opportunities to engage with the PCT and other NHS organisations through the annual conference and workshops. The review team, therefore, had some concerns about moving funding from the conference to support the new project.
- 4.17. The review team found it hard to identify routes for direct feedback and communication to BREHP, community groups or individuals of any changes (or otherwise) that have taken place as a result of consultation exercises; or ways that this information is being brought together across NHS organisations.

Data and information

- 4.18. Bristol PCT has invested in collecting and using quantitative data in particular. More emphasis, however, needs to be given to the value of 'soft' qualitative information, collecting this information systematically and feeding it into a structure that can create change. The PCT should look at strengthening ways of sharing information between NHS organisations and community groups about patient experiences for BME communities and for ensuring this informs commissioning decisions.

Culturally competent care

- 4.19. The review team had some concerns about the practice of customer care and culturally competent care in some services. Delivering culturally competent care goes beyond providing training and Bristol NHS organisations need to ensure that any training/quality standards results in changes in staff attitudes and practice.

5. Recommendations

- 5.1. The peer review identified a number of areas where there is scope for further development. The following section sets out main recommendations and suggested next steps that can support Bristol PCT to move forward in its objectives for capturing BME service experiences, responding more effectively, and demonstrating service change. Communication and information are central to this change process – with communities, staff, within and between departments, and with NHS and other partners. The recommendations look first at the new customer service project and PALS and then move on to external and internal communication systems.

New customer service project

- 5.2. The PCT should maximise the benefits from developing the new project and continue to ensure that communities and front-line staff own it and use the new system. They should be involved in design, implementation and evaluation of the project. The PCT should make sure that the new initiative is *tightly bounded* so it stays effective and build in evaluation at an early stage. Buy in from the top team is essential to review the capacity of the new service and PALS.

PALS

- 5.3. The PCT should take the opportunity to review/reconfigure PALS alongside the new project. Some suggestions include:
- widespread promotion of PALS across voluntary and community sector groups and consider re-branding
 - confirm what the service can realistically offer (to gain trust and credibility)
 - use of council neighbourhood forums (and feedback sheets from these) to promote PCT/PALS and bring feedback into the PCT
 - consider a more 'independent' base, for example an accessible shop front
 - target the next PALS vacancy to BME communities and, if appropriate, use the Race Relations Act to appoint a BME staff member
 - extend use of integrated report by breaking down data gathered by PALS, and making it more prominent by agreeing patient experience indicators and using these when carrying out contract reviews etc.

External communication and information

- 5.4. An organisational message about race equality should be sent out more strongly by the PCT. A series of chief executive/senior management roadshows could promote good practice, share

intelligence/data and any changes made in response to community concerns. This would increase confidence (of communities and frontline staff) and begin to change perceptions. Continued engagement at senior level with the national agenda on race equality issues will also support this organisational message.

Systems and feedback mechanisms

- Learn from the new project and develop more robust systems to capture and monitor patient concerns, develop solutions, and feedback to communities, whether or not changes have been made. Use PPI forum/patient groups as well as community groups to gather information.
- Develop clear practice/standards about providing feedback on actions resulting from concerns and problems raised by communities and individuals.
- Improve feedback mechanisms to BREHP from PALS/complaints data as well as the patient experience information that comes out of the new project and other consultation exercises. This would help to increase trust with community groups and may help to breakdown some of the barriers to existing patient comment and complaint mechanisms.
- Actively extend the consultation net so it picks up a broader section of communities and reaches grass roots. This should include new arrivals and would help to obtain more robust data from new groups. Interpreting services need more investment in some of the *new* languages spoken in Bristol.

Commissioning/contracting

- Demonstrating the impact of patient involvement/experience - how information on the patient experience has been gathered and used to improve services could be stipulated in SLA requirements. The PCT would need to develop benchmarks to review contracts/SLAs against (use of) patient experience and be clear about how this will be measured.
- The PCT as commissioner, could also stipulate feedback from its commissioned services on equality and diversity issues.
- There could be more effective use of PALS intelligence in all commissioning.
- Commissioners should build on their desire to develop responsive services and be more 'outward-facing'.
- Commissioners, in partnership with public health, should meet with/hold workshops with voluntary and community groups to support those who may be prospective providers.

Internal communication and information

- 5.5. Bristol PCT has a strong non-executive team in place to champion race equality but could utilise them more effectively to promote high profile leadership around BME issues.
- 5.6. Staff should feel more empowered to be part of the change process and encouraged to feedback patient/user concerns, develop ideas and solutions and follow these through. For this to happen the PCT could:
- develop and publicise clear communication channels within the organisation and build connections across the organisation
 - encourage staff to engage with other departments, organisations and communities
 - make sure issues raised by patients/users/communities are passed through the system and action taken to resolve them and deal with blockages if possible
 - ensure systems capture patients' concerns, whether any changes have been made, and how/when feedback was given
 - make better use of BME staff intelligence
 - skill up clinical/front-line staff so they are clearer about how to engage managers and commissioners to change services
 - mentor and value new staff
- 5.7. Knowledge Skills Framework (KSF) could also be used as a way of creating effective change by moving staff to higher levels on race equality.

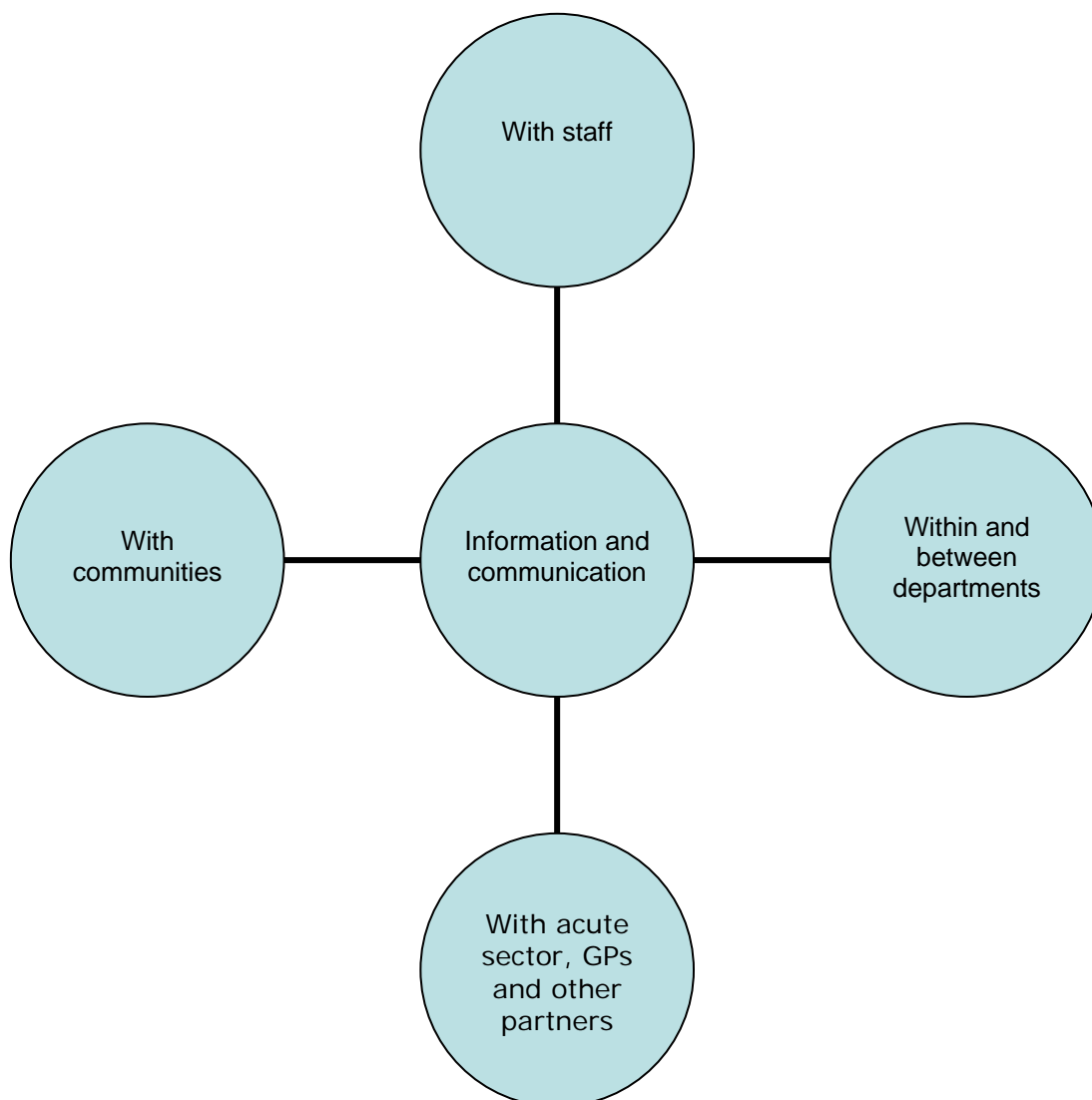
Culturally competent care

- 5.8. NHS organisations should 'go back to basics' particularly at the first point of contact with services. Initial assessments should include language, dietary needs, mobility, carer information etc. and ensure this information is passed on to other staff. Ongoing training should pick this up and include relevant standards of behaviour.

Effective linkages and joining up practice

- 5.9. Examples of good practice tend to be isolated and not joined up. These projects/initiatives need to be linked up to form a comprehensive approach.
- 5.10.** More integrated mechanisms could usefully be developed to capture all information from consultation exercises across the NHS. For example, each organisation could identify a 'virtual team' of staff from different departments to gather that information and feed it collectively into the system together with PALS, patient forum, and new project information.

6. The Change Process



Information and communication



Actions, feedback, builds up trust

APPENDIX ONE

Peer Review Team

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APPENDIX TWO

The peer review team would like to thank everyone who was involved with the peer review visit, for their open approach and willingness to share views and ideas. We would particularly like to thank Christina Gray and colleagues who organised the visit, Carl Muldoon for his technical and administrative support, and Esme and the team at the St Pauls Family Learning Centre for providing an excellent evening meal.

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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.