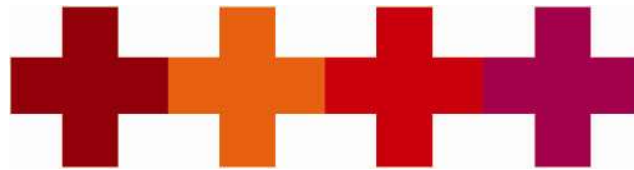


race for health



a transformational change programme

Central Manchester PCT Peer Review

13th/14th September 2006

Outcome paper

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1. Executive Summary

- 1.1. The Central Manchester PCT (CMPCT) Peer Review took place on the 13th and 14th September 2006. 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'.

Theme and Key Questions

- Is CMPCT designing a **commissioning strategy** that will meet the needs of all communities in Manchester?
- How effectively is CMPCT **engaging with Black and Minority Ethnic (BME) communities** in the development of the strategy?
- Is CMPCT using its **information sources** effectively to inform its commissioning strategies?

Overview

- 1.2. Central Manchester PCT is a founder member of the Race for Health Programme. It is now being merged, with North and South Manchester PCTs into a single organisation. The new merged PCT, Manchester PCT, will have a combined commissioning strategy and will be developing Practice Based Commissioning (PBC), which will have a huge impact on services delivered to BME groups. This is therefore, an opportune moment to take stock of CMPCT's activities and policies to date.
- 1.3. Central Manchester PCT serves a very diverse population. According to 2001 census data, around 31% of the area's population is from a black or minority ethnic group, compared with the city's average of 19%. The largest ethnic groups in the PCT's area are Pakistani, Black Caribbean and Black African.

Strengths

- 1.4. Manchester PCT, with its strong strategic links with the City Council and good links with the BME voluntary sector, has the **opportunity to build on these relationships** to develop and commission integrated health and social care services that more effectively meet the needs of its BME population. CMPCT has several examples of best practice in engaging BME communities and can take forward its commitment to diversity and equality in a meaningful way in the newly formed Manchester PCT. The close working relationship between CMPCT and Manchester City Council should be commended; a good example of this is the ongoing joint work on Agenda 2010.
- 1.5. Given the extensive networks with the BME community, CMPCT is in a **strong position** to develop a commissioning strategy that builds on these links and truly engages with and meets the needs of BME communities. The BME community and voluntary sector is

a valuable resource in that is informed, diverse and knocking on the door to be involved in the process. The BME voluntary sector also sees the need for an effective health promotion programme that meets the needs of BME communities and has signed up to taking part in providing a programme of this type. In practice, this could take the form of the BME voluntary sector being commissioned to provide health promotion services to BME groups and/or being involved in the development of a commissioning strategy that takes account of the needs of BME groups.

Outstanding Questions and Challenges

- 1.6. The Review Team felt that the following areas needed more development:
- More development and understanding was needed around the **collection and effective use of ethnic monitoring data**, including CMPCT failing to systematically collect ethnic monitoring data on service users from its own 'provider side'.
 - There was consensus among members of the Race and Health Forum that no BME voluntary sector group is currently linked into the **development of PBC** and that the CMPCT group working on PBC seemed unclear how to effectively engage the BME voluntary sector.

Recommendations

- 1.7. The following recommendations were made by the review team:
- The new commissioning strategy should proactively try to **engage BME groups**. PBC needs to become a key part of the Race Equality Scheme, and it needs to be proactively monitored to ensure it is effectively delivering services to Manchester's BME communities.
 - Manchester PCT needs to **improve its data collection**, which it bases its commissioning decisions on. Existing **ethnic monitoring data available from CMPCT** needs to be used far more effectively.
 - Good **recruitment practices** with BME groups which have been developed at ground level by CMPCT needs to be mainstreamed, and the new Manchester PCT needs to be more proactive about recruiting BME staff.
 - A key question Manchester PCT needs to address is where race equality sits in the **new management arrangements**. It will need to be held at a high level if current progress is to be maintained.

2. Introduction and Theme for the Review

- 2.1. The Central Manchester PCT (CMPCT) Peer Review took place on the 13th and 14th September 2006. The visiting team of peers included representatives from Bradford, Bristol, Ealing, South Birmingham and Wolverhampton PCTs. It also included Central Manchester's Race for Health Thinking Partner, the National Director of Race for Health, a representative from the Department of Health and the learning programme coordinators, Shared Intelligence.
- 2.2. The review team received a number of presentations from the PCT's management, including its Chair, Chief Executive and Director of Public Health, and the Deputy Chief Executive from Manchester City Council. The team also spoke to a range of PCT staff at various grades and from different directorates/services, and met representatives from the community and voluntary sector. The review took place over an evening and a full day, with time set aside for the team to discuss and formulate its findings and briefly present these back to CMPCT.
- 2.3. This paper sets out the review team's findings and recommendations, based on conversations that took place whilst visiting the Trust, and informed by documents provided in advance to the team. It is drawn entirely from their discussions on the day, and as such aims to provide a set of 'informed reflections' on the PCT's work on racial equality and diversity.
- 2.4. Central Manchester PCT is a founder member of the Race for Health Programme. It is now being merged with North and South Manchester PCTs into a single organisation. The new merged PCT, Manchester PCT, will have a combined commissioning strategy and will be developing Practice Based Commissioning (PBC), which will have a huge impact on services delivered to BME groups. This is therefore, an opportune moment to take stock of CMPCT's activities and policies to date.

2.5. The Review focused on three interlinked aspects:

- Is CMPCT designing a **commissioning strategy** that will meet the needs of all communities in Manchester?
- How effectively is CMPCT **engaging with Black and Minority Ethnic (BME) communities** in the development of the strategy?
- Is CMPCT using its **information sources** effectively to inform its commissioning strategies?

3. Background and Context

Manchester

- 3.1. Over the past 15 years, Manchester has reinvented itself, with world-class sports facilities, expanding service and creative industries and thriving universities bringing new money and jobs to the city.
- 3.2. This economic growth has brought in more than £2bn of private investment and created 45,000 new jobs over the past ten years. However, despite this renewed success and pride, Manchester is still tackling the problems left by several decades of industrial and economic decline in the second half of the 20th century. Economic and social problems remain, but Manchester is looking positively to the future and has an aim that by 2015, the quality of life in the city will be second to none.

Population

- 3.3. Figures from Manchester Joint Health Unit (JHU) show that Central Manchester PCT has a resident population of over 160,000 patients (mid-2002). However, according to March 2004 figures from Manchester JHU, CMPCT had a GP-registered population of over 190,000 patients. Although not strictly comparable due to the time between their collection (2002/2004), these figures suggest that there is a significant difference (around 30,000 people) between CMPCT's resident and GP-registered populations.
- 3.4. This variation in population is influenced by the large number of students living in the area. At the time of the 2001 Census, around 22% of CMPCT's population was between 16 and 24, compared with 18% of the population of the city as a whole. Some 27% of the PCT's working age population (aged 16 to retirement age) said they were students.

Ethnicity

- 3.5. Central Manchester PCT serves a very diverse population. According to 2001 census data, around 31% of the area's population is from a black or minority ethnic group, compared with the city's average of 19%. The largest ethnic groups in the PCT's area are Pakistani, Black Caribbean and Black African. At the time of the 2001 census the ethnic breakdown was as follows:

- Pakistani 9.8% (13,609)
- Black Caribbean 4.5% (6,309)
- Black African 3.3% (4,577)
- Indian 2.2% (3,092)

- Bangladeshi 2% (2,827)
- Chinese 1.8% (2,476)

3.6. Additionally, 17% of the population was born outside of the UK or other EU countries, compared with 11% of Manchester's population as a whole. BME communities are not distributed evenly across Central Manchester. In the Longsight and Moss Side neighbourhoods, more than half the population is from a BME group.

Health in Manchester

3.7. Health inequalities between Manchester and the rest of England have, however, been worsening over recent years. In 1997-99, the gap in life expectancy at birth between Manchester and the rest of England was 5.4 years for men and 3.6 years for women. If current trends continue, by 2011 the gap will be 7.9 years for men and 5.5 years for women. The Manchester local public service agreement acknowledged that reversing this trend was unrealistic, and consequently set a local target to slow the rate at which Manchester's life expectancy diverged from the national average. The target was:

By December 31st 2004, to reduce the expected gap in life expectancy at birth between England and Manchester to 6.2 years for men and 4.3 years for women from an expected gap of 6.6 years and 4.6 years respectively.

3.8. Inequalities in health are closely related to inequalities in socio-economic status, with those who experience greater levels of deprivation and social exclusion tending to have poorer health outcomes. Within Manchester, this social gradient can be seen clearly. At a crude level, there is a difference in life expectancy between North and South Manchester PCTs of over four years for men and almost two years for women; at ward level, a clear correlation ($r=0.76$) can be seen between standardised mortality ratio and the index of multiple deprivation.

3.9. This pattern illustrates that one of the key tasks in tackling health inequalities is targeting services and initiatives to more deprived communities, whether geographic or based on a community of interest. Therefore, while the City's Strategic Health Plan is aimed at the whole city, the inequalities and need for targeting makes it clear that a neighbourhood focus is a vital strand of the overall strategy for health improvement.

3.10. Improvements in Manchester's overall health should therefore, where possible, be made by improving the health of those lower down the social gradient faster than those further up.

Tackling the major killers in Manchester

- 3.11. Manchester has some of the most challenging health problems in the country. Compared with national averages, people in Manchester are:
- 31% more likely to die of cancer
 - 28% more likely to die of coronary heart disease (CHD)
 - 68% more likely to commit suicide
 - 64% more likely to die as a result of an accident
 - 66% more likely to die of a respiratory disease

Central Manchester PCT

- 3.12. Central Manchester PCT is a local NHS organisation responsible for providing a range of community-based health services. The PCT also commissions hospital services for people who are registered with a GP within the PCT boundaries. Most of these secondary care (hospital-based) services are commissioned from Central Manchester and Manchester Children's University Hospitals NHS Trust. The standard governance structure of a PCT comprises a Board and Professional Executive Committee (the clinical arm of the PCTs structure). Central Manchester PCT was formed on 1st October 2000 from Manchester Health Authority, East and West Primary Care Groups (PCGs).
- 3.13. The PCT covers 14 health related centres (8 health centres, 2 clinics and 4 other centres), and includes 41 GP Practices with some 100 GPs. Central Manchester PCT also covers 35 pharmacies, 23 optometrist practices and 28 dental practices. The PCT also provides many city-wide services for the three Manchester PCTs, including the Link Worker Service.

Joint working between CMPCT and Manchester City Council

- 3.14. A strength of statutory services in Manchester is the close working relationship at a senior level between CMPCT and Manchester City Council. A good example of this collaboration in practice is the Children's Board and positive collaboration has also arisen from joint work around Every Child Matters, despite a number of challenges needing to be overcome initially. Another example of effective partnership working is the Joint Health Unit which comprises of staff from both the local authority and the CMPCT. Manchester City Council has also taken on tackling health inequalities and improving access to community services as one of their key issues.

4. Findings

- 4.1. The review team heard evidence and views from a number of representatives and groups. These are grouped in five groupings: the Medicines Management team; Agenda 2010; PPI, PALS and Public Health Intelligence; Local Area Groups (LAGs) and District and Locality Groups; and the wider community.

The Medicines Management team

- 4.2. The Medicines Management team described several local initiatives which focused on engaging BME groups to the review team. These examples include:
- The Active Live For All (ALFA) Team provides an exercise on prescription and a women only swimming programme. The exercise programme responded to feedback, particularly from Asian women, that they could not go to classes, so a 'home activity guide' was devised. This included pictures, exercise diaries and a one-off workshop. Participants were then followed up at six and 12 weeks by a phone call. The programme also trained walk leaders to lead walks safely across parks and delivers a sugar group which supports diabetes patients. The review team felt that the programme could benefit from revisiting the barriers that women needed to overcome to take part in exercise initiatives, and develop additional solutions to the ones they had already implemented.
 - The ALFA Team negotiated three women only swimming sessions a week with Manchester Leisure, two beginners' sessions for non swimmers and one intermediate session for more advanced swimmers. All sessions are strictly female only, with a female teacher and no poolside/spectator access for men. The sessions can hold 20 people each and all three are full most weeks (two sessions used to be provided but a third was needed to cope with demand). Manchester Leisure fund the sessions but ALFA clients are the only people that can attend at present due to capacity.
 - CMPCT are using **film and DVDs** as a means of engaging BME groups, including making a film to attract more non English speaking patients to patient education sessions, which provide advice on exercise, diet and medication.
 - CMPCT is a pilot site for producing information on **osteoporosis** for patients whose first language is not English. This was done through a DVD showing various scenarios that patients might experience, including risks of Vitamin D deficiency. Similar work was also carried out on the patient

journey for chronic Cardiac Pulmonary Disease (CPD) with voiceovers in Arabic, Somali, Urdu and Mandarin using a translation resource called Reach. CMPCT is encouraging GPs with DVDs to use these health promotion resources in their waiting rooms.

- Work had also been undertaken with the Somali, Bangladeshi and Asian **carers groups** to develop new health promotion programmes.

Meeting with local authority Agenda 2010

- 4.3. Agenda 2010 is the key group in Manchester charged with promoting race equality in the city. The Local Authority, CMPCT and other public sector partners have been working together on Agenda 2010 since 1999 to promote Race Equality. The Associate Director of Access and Inclusion for CMPCT chairs the race and health group that brings all the NHS trusts together, including trusts providing adult, children's and social care, and mental health services.
- 4.4. Over 20 race equality impact assessments have been started across the services. All have had issues with data and it is not yet clear what outcomes have resulted from them.
- 4.5. Manchester PCT now has a big opportunity to ensure that the evidence from **race equality impact assessments** are used in developing practice based commissioning. Much can be learnt from practice developed by local authorities and social care commissioning where there is a framework for penalising providers who do not meet their targets while also ensuring that appropriate incentives are put in place.
- 4.6. The usefulness of **data from super output areas** was discussed as a means of measuring the impact of health initiatives on health inequalities at a neighbourhood level. The neighbourhood delivery model in East Manchester has much potential for this, as do North Manchester's Health Hubs and Central Manchester's Local Area Groups.

PPI, PALs and Public Health Intelligence

- 4.7. The review team heard that the **2001 census ethnic monitoring data** was out of date and that attempts to obtain new data had been difficult. Problems had included half the population being classified in the 'other' category and data not being updated. It was acknowledged that Manchester PCT needs to get wiser about using ethnic monitoring data in terms of how it both collected and used this data.
- 4.8. CMPCT acknowledged the importance of **patient involvement** and hoped that the new PBC contracts would provide more reliable data.

- 4.9. In terms of GP engagement with the race equality agenda, Manchester GPs mirrored the population much better than most staff groups, although this does not necessarily equate to improved engagement. The **GP contract** contains some sections on inclusive service delivery. However, it was felt that PPI had little leverage with GPs to increase their engagement with the race equality agenda.

Local Area Groups (LAGs) and District and Locality Groups

- 4.10. A number of local initiatives, including Sure Start, had been very successful in recruiting high levels of BME representation within their workforce. Members of the community had begun as volunteers and then received training to become staff. In this way these initiatives were not only providing a service but also equipping members of the community with skills.
- 4.11. The **Expert Patient Programme** has high levels of BME participation and has won awards. It has had a strong impact on improving lives and raising skills.
- 4.12. **Screening co-ordinators** have also been able to increase service uptake in cytology, while an NRF-funded project with Somali women has helped to dispel myths about smear tests.
- 4.13. However, these examples of good BME recruitment practice **have not yet been mainstreamed** and it was acknowledged that CMPCT has far to go in this area.
- 4.14. **LAGs** have been a useful mechanism for feeding information into the board and have worked well for confident local people. Significant investment has been made in community involvement, although it was hard to measure its impact.

The Community Perspective

- 4.15. The peer review team met more than 15 representatives from the BME voluntary sector at the Manchester Race and Health Forum. Representatives divided into three groups to discuss the key issues. The outcomes of these discussions are described below.

Communication between CMPCT and the Manchester BME population

- 4.16. Members of the Race and Health Forum felt that communication between CMPCT and Manchester's BME population was good. Examples of this include an **information leaflet** describing health service provision being delivered to every household in the CMPCT area. This was seen as very positive, although some members suggested that people living in blocks of flats seemed less likely to receive leaflets than those living in other types of accommodation. A **guide to health services** opening times over the Christmas period was also well received. However, there was a feeling in some quarters that CMPCT could do more to tell its

residents about services, for example by making more use of the local press.

- 4.17. The development of the **PCT website**, which includes a list of BME voluntary organisations, was also viewed positively. However, the involvement of members of the BME voluntary sector in this was felt to have been fortuitous as one member of the BME voluntary sector has a dual role with the PCT. Work on the website was not part of a strategic approach to engage the BME voluntary sector.
- 4.18. It was suggested that the PCT could set up a **web based discussion forum**, where people's concerns could be raised and answered.

Commissioning

- 4.19. The BME voluntary sector thought that an effective commissioning strategy needs to understand and **consult with the local community** and should develop a rigorous process to assess community needs. BME representatives claimed that the BME community have not yet been consulted or engaged with on the commissioning strategy. One view was that an explicit community consultative process needed to be developed for the new commissioning strategy which set out milestones and opportunities for the community to meaningfully engage with the process.
- 4.20. The BME voluntary sector perceived that there was a **capacity issue** within the commissioning team. For example, it was felt that if one commissioner looked after 50 contracts, they would only be able to spend one week a year on each contract. Another perception was that commissioners might be afraid of digging deeply into the needs of BME communities in case they uncovered more unmet need.
- 4.21. The BME voluntary sector have asked for the current **strategic investment plan** in the voluntary sector, yet have so far received nothing. It was suggested that CMPCT should provide a list of all the community services it commissions to interested parties, and that a list of key commissioners could be sent relevant information when organising events such as conferences.

Ethnic Monitoring Data

- 4.22. Members of the Race and Health Forum said that CMPT collected much data from their providers, but they were unclear how this information was used to inform **strategic commissioning decisions**, including Quality Outcome Frameworks (QOF) used in primary care. Concern was also expressed about a perceived lack of public health knowledge on specific local BME health issues.

Practice Based Commissioning (PBC)

- 4.23. There was consensus among members of the Race and Health Forum that no BME voluntary sector group is linked into the **development of PBC** and that the CMPCT group working on PBC seemed unclear how to effectively engage the BME voluntary sector. There was a view that CMPCT wanted the Race and Health Forum to inform other BME groups about PBC.
- 4.24. The BME voluntary sector were concerned that **GPs** would not recognise and value the work of their sector. A suggested solution to this problem was for the Commissioning Strategy to formally acknowledge the importance of the BME voluntary sector. Another view was that Manchester PCT needs to act as a broker between GPs and the BME voluntary sector and inform GPs of the benefits of working with it.
- 4.25. In the mind of one BME representative, GPs' views are informed by the patients who use their services. This was felt to raise the question of how the views of communities who currently under use GP services and have significant health needs can be factored into the PBC equation.
- 4.26. Some BME groups were concerned about the impact that PBC would have on **dispersed BME communities** such as the Chinese community.

Engagement with BME Communities

- 4.27. The Peer Review Team heard that there are two BME forums in Manchester - a Black Community Care Consultative Forum organised by the Local Authority and the Race and Health Forum, which feeds into the PCT. This leads to some **duplication** as they serve the same purpose but feed into different statutory bodies. Some BME voluntary sector representatives go to both while others go the body that primarily commissions their organisation.
- 4.28. One view was that if Manchester PCT wants more engagement with the BME voluntary sector, it should pay for voluntary sector staff time spent attending meetings. This was because, while attending these meetings, voluntary sector staff are unable to provide direct services to their communities.
- 4.29. A number of ideas were suggested that could **increase engagement** between the BME voluntary sector and Manchester PCT. These included the CMPCT commissioning group attending the Race and Health Forum to find out its views. Another option was to have a named senior director with whom the BME voluntary sector could have high level discussions, and a named middle manager with whom they could have more regular contact. In this model the middle manager would have the time to take practical steps that would impact on health service delivery. A third view was that statutory bodies need to 'get out more' to forge

closer links with the BME voluntary sector and that all senior and middle managers, and frontline workers should engage the BME voluntary sector as part of their jobs.

- 4.30. There are some areas where communication between CMPCT and the Race and Health Forum could be improved. For example members of the Race and Health Forum were unaware that they could request copies of the findings of Race Equality Impact Assessments although they are available. However CMPCT's view was they had commissioned the Race and Health Forum to ascertain the views and experiences of service users and carers, and were awaiting feedback from the forum before publishing their full Race Equality Impact Assessments.
- 4.31. It was also suggested that CMPCT does not provide any evidence that community consultation leads to specific hard outcomes or changes in the way health services are delivered and that it could be more clear about what it requires from the BME voluntary sector.

Service Level Agreements (SLA)

- 4.32. There was a view that the voluntary sector's SLAs with CMPCT are uniform and lacking in detail. A common view was that no BME voluntary group had a SLA requiring them to liaise with hospitals and GPs about improving the patient journey, even though this is one of the services which BME communities value most from these groups. For instance, the hospital appointment system was felt to work well if a person spoke English, but not if they didn't. If a patient wants to change their appointment then they need to give a password which comes with their appointment letter. Many people who have English as a second language find this difficult. The onus for resolving this type of issue often falls on the BME voluntary sector.
- 4.33. A view was expressed that CMPCT needs to operate in a smarter way to enable the BME voluntary sector to grow and develop and to put it in a stronger position to receive commissions to deliver services to BME communities in future. It was suggested that Manchester could learn from Wales's experience of a Community Commissioner model, whose sole purpose is to put voluntary sector organisations in a stronger position to be commissioned. This model of commissioning does not treat all organisations as equal and puts specific development/capacity building work into the voluntary sector.

5. Analysis

- 5.1. The following section assesses in greater depth Central Manchester PCT's strengths and areas for development identified by the review team.

Strengths

- 5.2. Manchester PCT, with its strong links with the City Council and good links with BME voluntary sector, has the **opportunity to build on these relationships** to develop and commission health services that more effectively meet the needs of its BME population. CMPCT has several examples of best practice in engaging BME communities and can take forward its commitment to diversity and equality in a meaningful way in the newly formed Manchester PCT. The peer review team was impressed by the dynamism and honesty of the host team and viewed much of the provider work delivered by CMPCT very positively.

Commissioning and the BME voluntary sector

- 5.3. CMPCT is in a **strong position** to develop a commissioning strategy that truly engages with and meets the needs of BME communities. It has a valuable resource in a BME community and voluntary sector that is informed, diverse and knocking on the door to be involved in developing a commissioning strategy. The BME voluntary sector also sees the need for an effective health promotion programme that meets the needs of BME communities and has signed up to taking part in providing a programme of this type. In practice this could take the form of the BME voluntary sector being commissioned to provide health promotion services to BME groups and/or being involved in the development of a commissioning strategy that takes account of the needs of BME groups.
- 5.4. Previous investment by social services in the capacity of the local BME voluntary sector was evident. This will provide Manchester PCT with strong foundations to **develop and extend partnerships** between the statutory sector and the local BME voluntary sector in providing and commissioning health services in the future. It should be noted that not all areas in the country are currently in this position.
- 5.5. Where members of the BME voluntary sector were well networked in with CMPCT and knew the right officer to ask about pertinent issues, they were able to engage effectively with CMPCT.

Joint working between CMPCT and Manchester City Council

- 5.6. The close working relationship between CMPCT and Manchester City Council should be commended; a good example of this is the ongoing joint work on Agenda 2010. There is a clear strategic vision of how the partnership can operate between the key

agencies in the city, including taking forward the Local Area Agreement (LAA). There is a strong commitment to take forward the work on a joint race equality strategy for the PCT, City Council and other public sector bodies operating in Manchester. There is also a strategic recognition within the Council that 'narrowing the gap' between those who have benefited from the economic regeneration which has transformed the economic prospects of City and those who have not is crucial if the deep rooted inequalities in poverty and health which currently exist are to be addressed effectively. The Council's neighbourhood agenda is a very important asset to the PCT in this respect.

Health promotion programmes that targeted BME groups

- 5.7. The peer review team thought that much of the practice developed through health promotion programmes such as the ALFA Team was superb. It noted some very **innovative ideas** around labelling prescriptions, with the 'pills and spills' project and medication reviews good examples of this.

Recruitment of local BME groups to various new health initiatives

- 5.8. CMPCT has successfully recruited members of BME communities to a number of health initiatives, including Sure Start, the Expert Patient Programme, screening co-ordinators and health trainers.

Other strengths

- It was clear that statutory bodies in Manchester had put significant investment into **community involvement**.
- Using the **best qualities from the different PCTs** in Manchester could have a positive impact on the new, merged organisation.
- The peer review team recognised the importance CMPCT places on **patient involvement**.
- **Local Area Groups** were seen as a good springboard for engaging local communities in the commissioning strategy and doing further community engagement work.
- The **strong working relationship** between CMPCT and the local authority and the **integration** between health and social care were seen as major strengths.
- The **lead role** CMPCT has played in race equality was recognised across the Manchester healthcare economy.
- The **Race Equality Impact Assessment Process**.
- The **frontline training** undertaken on race equality awareness.

Questions and challenges

- 5.9. There were some areas where the review team identified challenges or where questions remained.

Ethnic monitoring data

- 5.10. A number of challenges emerged around the **collection and effective use of ethnic monitoring data**, including CMPCT failing to collect ethnic monitoring data on service users from its own 'provider side'. In primary care, the collection of ethnic monitoring data was seen as poor and unreliable with only one practice piloting it. There is no widespread staff training program in CMPCT in the collection and purpose of collecting ethnic monitoring data. Ethnic monitoring data was also not consistently collected from the monthly PALs meetings and, where it had been collected, it was not shared and disseminated as effectively as it could have been.

Clarity of race issues at the middle management level

- 5.11. There did not appear to be much **clarity around issues of race** at middle management level. The peer review team also perceived that, although the senior levels of the organisation were completely signed up to the race equality agenda, middle management were not to the same extent. This could be due to middle managers operating in an environment where they have to deliver against many targets, and that achieving race equality targets is not felt to be a top priority. There was also a lack of clarity on how the Patient Participation and Involvement agenda worked with groups of patients who were regarded as 'too difficult to involve' and how their views were obtained and used in the design and development of services.
- 5.12. The team also noted that there was reluctance in the documentation to use **robust and definitive language** regarding race equality issues.

Communication between BME voluntary sector and CMPCT

- 5.13. Communication between CMPCT and the BME voluntary sector was not systematic and would benefit from being **more proactive**. Where it worked well tended to be where personal relationships had developed between individuals, although this was not yet part of CMPCT's organisational memory.
- 5.14. The BME voluntary community sector lacked understanding about the **levers for change**, although a number of organisations had tried to establish what these were. For example, BME voluntary sector organisations were unaware they could request the findings from race equality impact assessments.

Practice Based Commissioning (PBC)

- 5.15. The BME voluntary sector had some concerns about how practice based commissioning would impact on the provision and development of services provided to BME groups. These concerns included:
- The BME voluntary sector had not been able to engage in the development of **PBC strategy**, and those charged with

developing PBC strategy were not clear how to engage with the BME voluntary sector.

- The impact PBC would have on **dispersed BME communities** such as the Chinese community.
- The use of **smaller geographical areas** to commission services could lead to a lack of strategic direction.

Recruitment Practices

- 5.16. Mainstream CMPCT recruitment practice is **not proactively engaging BME communities**. At the moment, this is mainly seen as the remit of special healthcare initiatives such as the screening co-ordinators, which are seen to have a strong emphasis on engaging the local BME community. A key issue is that good practice at ground level on race equality issues, often within specific healthcare initiatives, needs to be mainstreamed into CMPCT's core work.

Other Challenges

- Better **evaluation** of race equality outputs needs to be undertaken, for example by looking at the impact of investment in the community sector on delivering specific race equality outcomes.
- There was a perception within CMPCT that there was a **lack of capacity** in terms of time and money to fully deliver on the race equality agenda.
- There was an implicit assumption that because **GPs** were themselves ethnically fairly representative of the population, they would be better able to meet BME needs.
- There are few levers in the **GP contract** to increase GP involvement in the PPI agenda.
- The new Manchester PCT will need to develop a coherent approach to the council's **neighbourhood level work**. This should be seen as a significant opportunity to build on best practice that already exists.
- A key challenge is ensuring that colleagues who are key allies and advocates with a passion for BME health equality are **working together**. This includes the ward based community engagement workers and GPs who are breaking new ground and who have a passion for the service. For example, one GP had done some pioneering work on domestic violence.

6. Recommendations and areas for development

- 6.1. The following section sets out the review team's key recommendations and the areas for development identified during the review.
- Manchester PCT needs to **improve its data collection**, on which it bases its commissioning decisions. Existing **ethnic monitoring data** needs to be used far more effectively.
 - The PCT needs to develop a **shared infrastructure and communication** system that is linked effectively to BME groups that may not be neighbourhood based.
 - The PCT should ensure that there is a strong **cultural awareness training programme**/staff development. Race awareness training needs to be provided on a continual and systematic basis.
 - Manchester PCT needs to champion **community involvement** within Practice Based Commissioning.
 - The PCT needs to ensure that its **commitment to race equality** jumps off the page and that this vision is carried through and shared at all levels.
 - Manchester PCT needs to take advantage of the new opportunities that the development of the newly merged PCT presents and **build on existing best practice** developed by CMPCT. It is important that the newly merged organisation does not lose its race equality focus - in fact, race equality needs to be embedded and fully integrated in to the new PCT.
 - A key question Manchester PCT needs to address is where race equality sits in the **new management arrangements**. It will need to be held at a high level if current progress is to be maintained.

Developmental Ideas.

- 6.2. These points were made by members of the peer review team, but time constraints made it impossible to gain consensus from the whole team on their merit. Manchester PCT may, however, want to consider them. These recommendations are divided into four categories.

Commissioning

- The new commissioning strategy should proactively try to **engage BME groups**. Practice Based Commissioning needs to become a key part of the Race Equality Scheme and needs to be proactively monitored to ensure it is effectively delivering services to Manchester's BME communities. Where possible,

holding mechanisms should be put in place to ensure GPs are committed to specific areas of race equality, such as ethnic monitoring, before being provided with any extra discretionary resources Manchester PCT might provide to primary care services.

- Much can be learnt from practice developed by local authorities and social care commissioning, where there is a framework for penalising providers who do not meet their targets while also ensuring that appropriate incentives are put in place. Risk analysis should be undertaken of Manchester PCT's commissioning strategy to measure the positive and negative impact it is likely to have on BME communities. Manchester PCT should also major on its scrutiny role, ensuring its providers deliver services that effectively meet the needs of Manchester's BME community.
- Manchester PCT needs ensure that the views of service users and carers feed into its monitoring systems.
- Manchester PCT needs to be more pro-active about publishing the good work they are undertaking regarding **race equality impact assessments**, and there is a requirement that these are published. Manchester PCT must ensure Race Equality Action Plans feed directly into the development of Practice Based Commissioning.

Effectively Engaging the BME Voluntary Sector

- The need to develop a **link between the commissioning team and the BME community** was clear; how best to operationalise this was not. One option would be to have a named person or persons within the commissioning team as key links to the BME voluntary sector. This would develop clear lines of communication and increase clarity. However, the danger of this approach is that race equality issues are seen as being the remit of just one or two people and not everyone's responsibility, and this may not be the best way of delivering long lasting embedded change. An alternative would be to put linking with the BME community into the objectives of every member of the commissioning team, with their success at meeting this objective being regularly appraised.
- It was felt that the BME voluntary sector would benefit from being provided with some **business development support**, which would enable the sector to be in a stronger position to be commissioned by the PCT to provide services to BME groups. The Welsh experience of utilising a Community Commissioner Model was seen as relevant. The sole purpose

of Community Commissioners is to enable voluntary sector organisations to be in a stronger position to be commissioned to provide statutory services. This development could also lead to the BME voluntary sector being able to engage more effectively with the development of the commissioning strategy for Manchester.

- **Service Level Agreements** used between the PCT and the BME voluntary sector needed to become more sophisticated. This would benefit both parties. A 'one size fits all' approach is currently used which makes it harder for commissioners to performance manage outcomes and for providers to understand exactly what they are required to deliver.
- Manchester PCT could work more closely with community groups in the design and development of new **health promotion programmes**. Community groups could then help to sponsor these programmes. More proactive GPs could also be persuaded to take the lead in sponsoring this work. It was thought important to get on the front foot so this work proactively engages BME communities.

Workforce

- All managers in Manchester PCT should have specific aims and objectives regarding race equality issues and these should form part of **managers' annual appraisals**. There was a view that managers needed to perceive race equality as a **core management competence** on a par with good financial management and people skills, and that until this cultural shift happens some managers would not engage with the agenda as effectively as possible.
- Good **recruitment practices** with BME groups which have been developed at ground level needs to be mainstreamed, and Manchester PCT needs to be more proactive about recruiting BME staff.

Strategy and Organisational Development

- Manchester PCT needs to develop a **strategic framework** to enable its race equality work to become more robust.
- The culture of partnership working at senior level with the City Council which was evident in CMPCT needs to be continued in the new Manchester PCT.
- Having an **associate director** responsible for race equality issues who had direct access to the organisation's Chair and

Chief Executive seems to have been very effective at facilitating positive change.

- A suggestion made by a member of the Race and Health Forum was that an **online forum** could be developed to facilitate a discussion between Manchester PCT and service users. Equality impact assessments must be published and should be uploaded onto the PCT website, which would increase access to these findings.
- There needs to be better **evaluation of outputs** produced by investment in the race equality agenda to ensure these resources are not being wasted.
- The local authority and the PCT need to develop a deeper understanding of a **shared vocabulary** on race equality.

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APPENDIX THREE

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APPENDIX FOUR

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.