

Lambeth PCT Peer Review

7th/8th February 2006

Outcome paper

Introduction

The Lambeth PCT Peer Review took place on the 7th and 8th of February, 2006.

The visiting team of Peers included representatives from Bristol North, Ealing, Haringey, Wandsworth and Westminster PCTs. The team also included the National Director of the Race for Health programme, Lambeth's Race for Health Thinking Partner and the learning programme coordinators, Shared Intelligence.

Over the course of the Review, the team heard a number of presentations from Lambeth PCT's management, including its Chair, Chief Executive and Directors of Public Health, Finance and Primary Care. The team also had the chance to meet Dr Richard Williams, who is behind a successful patient profiling project in Lambeth, and speak to a range of PCT staff from different service areas (full lists of Peers and participants can be found in the appendices to this report). The Review consisted of 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 the host PCT.

This paper sets out in more detail the Peer team's findings and recommendations. However, it is drawn entirely from their discussions on the day, and as such will provide – much like the day itself – a set of 'informed reflections' of Lambeth PCT's work in the area considered, rather than detailed research or in-depth analysis.

Theme and key questions for the Review

The thematic focus for the Review (selected by the PCT) was:

'How successful is Lambeth Primary Care Trust at collecting, recording, analysing and using ethnicity monitoring information (EM)?'

Key questions which the team were asked to consider included:

- Bearing in mind that it is largely non-computerised, is Lambeth PCT (LPCT) doing as much as it could to collect and use ethnicity monitoring information?
- How could LPCT improve how it uses ethnicity data to better inform the PCT about gaps in its services?
- What were the factors/conditions that enabled Dr Williams' project to succeed? Do any of these lessons have wider application?
- What other examples of good practice can be identified? How can this learning be captured and spread throughout the organisation?
- How is EM information fed into thinking and work around BME health inequality – or, in the absence of thorough EM, how is this work conceived and targeted, and how is the RES action plan driven forward?

Background and context

At the commencement of the Review, Lambeth PCT's Chief Executive, Kevin Barton and Director of Public Health, Ruth Wallis gave the Peer team an overview of the demographic makeup of the borough and the challenges facing the PCT.

Population

Lambeth is one of the largest and most culturally diverse boroughs in London. It stretches from the Bishops and Princes wards in the north to Streatham South and Gipsy Hill in the South, with Clapham to the west and Herne Hill to the east.

The borough's population is estimated to be around 250,000 across the 22 wards and is one of the most deprived in England and Wales, with particular concentrations of deprivation in some wards and neighbourhoods. About 38% of children are eligible for school meals (2002), a high proportion of homes are without central heating and overcrowding is a problem. Residents in the most deprived areas are more likely to have poorer health and lower life expectancy, as well as limited access to good quality services.

Lambeth has a higher than average number of young people aged between 20 and 40 and a highly mobile population (estimated at 42% mobility) with a high proportion of residents in temporary accommodation. The borough has large numbers of refugees and asylum seekers, homeless people and people with drug and alcohol problems, although there is a dearth of accurate data on these groups. There is a strong association between locality, race and deprivation in Lambeth.

Ethnicity

Around half of Lambeth's population is white British, and around half are from a minority ethnic background. Lambeth has well-established Irish, black Caribbean and black African communities, more recently settled Portuguese and Latin American communities, and asylum seekers and refugees from many countries. More than 150 languages are spoken in the borough.

However, the borough's ethnic profile and age profile need to be looked at together to get a true picture of Lambeth's rapidly changing population. Whereas almost all of Lambeth's older people are white, about 50% of births last year were to women of African origin. Although many of the borough's teenagers are from BME groups, many people in their 20s are white.

Health inequalities and race equality

In his presentation to the team, LPCT Chief Executive Kevin Barton emphasised the organisation's strong focus on public health, and more particularly on reducing health inequalities. As the proportion of BME people is so high in Lambeth - and the work of a public health organisation is essentially population-based - LPCT's leadership does not see achieving race equality in health care as a 'separate issue'.

LPCT does try to take account of practical differences between different ethnic and cultural groups, such as susceptibility to certain illnesses or prevalent lifestyle factors. It also wants to offer services that are managed and delivered in a way that is culturally sensitive.

However, overall the PCT wants to focus on common issues, particularly around the major causes of ill health and access to services that will improve health 'across the board'. Rather than supporting 'interesting but not necessarily sustainable projects' specific to BME people, by trying to address issues in an integrated, inclusive and needs-based way LPCT hopes no-one will be left behind – whether BME or white. The PCT believes that this approach will avoid complex discussions about differences and priorities and facilitate practical action.

Reflecting this convergence, LPCT has a single Board sub-committee – the Health Inequalities and Diversity Steering Group – which is chaired by the Chief Executive. The PCT is now recruiting a new assistant director to take this agenda forward (although there are already strands of work around equalities and diversity within the PCT’s HR and organisational development directorate - see below). The team heard LPCT’s self-diagnosis that the PCT hadn’t yet achieved ‘organisational coherence’ around race equality; despite good leadership, strong commitment and staff enthusiasm overall.

Partnership working

In recognition of the wider context for health equality (e.g. links with housing, employment and community safety), this theme runs through all of LPCT’s partnership-working, including its work with the LSP, Lambeth First. The PCT is well-represented at a senior level on several theme partnerships, and is increasingly looking towards Local Area Agreements as a tool to take cross-cutting work forward.

Ethnic monitoring in Lambeth

Robust ethnic monitoring (EM) is of increasing importance to the work of PCTs, particularly in their aim to reduce health inequalities and as they take on a greater strategic commissioning role. Murray King (Assistant Director for Service Improvement) spoke to the team about the role currently played by ethnicity monitoring and patient profiling within LPCT; some of its challenges and successes in this area; and the PCT’s intentions for EM in the future.

The importance of ethnic monitoring

Ethnic monitoring is seen as critical to Lambeth’s work, because, as for all PCTs:

- Without it the PCT and its staff have to rely on unwieldy, out-of-date census data for population information, supplemented by local intelligence.
- A good EM information resource allows the perceptions of frontline and clinical staff to be verified, and population trends to be measured and tracked over time. EM is often the most sensitive indicator of population change at the local level.
- EM gives the opportunity to begin to identify differences in risk-taking behaviour between ethnic communities, differences in prevalence and incidence of diseases, and differential use/experience of existing services.
- The collection and use of ‘softer’ EM information – gathered through community consultation, PALS activity and other user feedback – is critical to achieving this more sophisticated understanding.

Following analysis, the PCT can begin to develop strategies for intervention. This could include targeting and tailoring existing services differently or commissioning new services; and producing health promotion materials that meet different cultural and language needs.

Existing progress on ethnic monitoring/patient profiling in Lambeth

Examples of good practice around EM in Lambeth include:

- *IPRP* (the Individual Patient Registration Profile) - this project started four years ago and now has over 30 practices participating (covering 221,176 patients). The PCT provided a ‘substantial’ injection of cash to incentivise the collection of comprehensive patient profiling data and to fund training for practice staff.

- The *Datanet* project is strengthening the IPRP data for use as a research base, for projects examining the link between ethnicity and health/access to health services. However this work is supported by a charitable grant, not mainstream funding.
- The *new pharmacy contract* contains a health promotion element; this will pilot patient feedback questionnaires that collect ethnic data.
- A Health Equity Audit has been undertaken in relation to *Stop Smoking Services*, and the client database for this service includes ethnic data recording.
- The *Expert Patient Programme* records the ethnicity of its participants, and also supports the ongoing provision of the programme in a number of different languages, such as Hindi, Gujarati and Turkish.
- The *Child Health Master Index* includes ethnic data recording.
- A *needs assessment* of the tightly-knit Portuguese community in Stockwell has been used to influence the provision of local PMS pilots, Sure Start and other local programmes.
- The *Homeless Team* has started to monitor the ethnicity of clients attending clinics at hostels and day centres. In future SLAs negotiated with independent sector providers will include an EM requirement.

Past, present and future challenges to ethnic monitoring in Lambeth

The team were impressed by Lambeth PCT's progress in this area, and by the instances of good practice cited above. However, LPCT also highlighted the limitations of the EM information that is currently held. At the moment, data collection is not required in most instances and so remains relatively unsystematic. Further, although the leadership is committed to using EM and public health data to inform commissioning decisions, at present only a small amount of analysis is undertaken, making this difficult to achieve.

Specific challenges to ethnic monitoring were identified and described to the team by Lambeth PCT staff and management. These include:

- Lambeth PCT is working towards a comprehensive computer-based system (see below), though there is still some distance to go. Individual GP practices and services are creating and populating their own small databases but these are not necessarily consistent, and if data is not computerised it can be difficult to analyse in a systematic way.
- With so many competing demands on GP practices, getting them to take on additional activity that may be regarded as optional requires a mix of strategies. Champions are very important, and offering a financial incentive helps. It was hoped that the new GP contracts would promote EM; however the new Quality and Outcomes Framework (QOF) is unlikely on its own to provide sufficient incentive. This is something many PCTs are struggling with.
- Lambeth has a high list turnover - approximately a third of its registered population each year move in and out of the borough, change GPs within the borough, or are new registrations who are resident but did not have a GP. The PCT argues that, with only two thirds of the population remaining 'static', it is difficult to keep levels of data held steady, let alone increase them.
- The PCT's management (and particularly the commissioning function) find it hard to justify taking action when data coverage is only 40-50% of the total registered population; this in turn acts as a disincentive to both collection and analysis.
- Nationally, in the past more money has been made available to incentivise EM in acute services compared to primary care – LPCT hope that this will be rectified as more focus shifts to primary care and reducing health inequalities.

PAS and RiO

One of the key obstacles to EM in Lambeth is the widespread use of paper-based systems, and/or discrete computer databases. By 2008-9 a new national computer-based recording system should be available for use in the NHS. In case this doesn't happen or happens more slowly, LPCT plans to introduce a new Patient Administration System (PAS) and Clinical Information System (RiO) in the meantime, which are to be piloted in the coming months in three discreet areas of service provision (Intermediate Care, Foot Health and Specialist Children's Services).

The new system will enable the PCT to collect EM data electronically and interrogate it, which can then be used in a multiplicity of ways. However there may be issues with software compatibility (and therefore data migration) between the planned NHS system and RiO, which could necessitate staff having to enter data twice. This possibility has been raised at national level, and will remain a concern.

LPCT acknowledged that there will still be a need to 'clean' and standardise the existing paper-based and computerised data that has been collected up till now, in readiness for migration to a new system. This work will be phased and has already begun.

The Individual Patient Registration Profile (IPRP) and Datanet

The Review Team received a presentation from local GP Dr Richard Williams, instigator and coordinator of the Individual Patient Registration Profile (IPRP) project and Datanet.

In the late 1990s, Dr Richard Williams set up a patient profiling project in partnership with his local acute trust (the PCT did not yet exist). His work was inspired by a national project in 1993, which piloted the collection of ethnicity data in general practice. Drawing on the learning from this work, Dr Williams coordinated an initial group of 12 practices in Lambeth to collect patient data. The IPRP adds information on self-ascribed ethnicity, religious affiliation, language preference and the need for an interpreter to that routinely gathered from each patient registering with a general practitioner (although broader than the standard 16+1 EM categories, the data is able to be re-aggregated to these).

Once a practice is recruited:

- Computer templates are set up
- One-day training is held for practice and reception managers in issues of ethnicity and cultural diversity, practicalities of data collection, and data use
- Half-day in-practice training is provided for the primary healthcare team in cultural awareness and supporting patients to provide data
- Data collection and computer entry starts from newly registering patients, and a centrally organised questionnaire is mailed to all registered patients
- Data entry of returned questionnaires is fully funded
- Trainers offer more support where needed

Initial funding was provided by the North Lambeth Primary Care Group and Lambeth Southwark and Lewisham Health Authority. Lambeth PCT has supported the project since its creation in 2002; incentivising practices to get involved by funding the collection and entry of data. Other funding streams - such as from the Shared Services Project - have contributed towards the recruitment of more practices, and work towards centralising and standardising the data. Training for frontline staff and the provision of computer support has assisted practices with the administrative and technical demands, as well as 'winning hearts and minds' around routine patient profiling.

There are now 33 practices involved in the IPRP, although they are at differing stages of the process and some have had more success than others. Although the number of practices involved has continued to grow, there have been ongoing difficulties in producing templates and coding data, and a lack of organised support. Dr Williams is also aware of the need to convince clinicians who still see EM largely as a public health and HR issue.

Datanet

To date, there has been no mainstream resource available for actually using the data. However a successful joint application (with the Department of General Practice at Guys and St Thomas Hospital) was made in 2004 to the Guys and St Thomas charity to set up a research facility - 'Datanet' - to use the data from the IPRP. The award, of £280,000 over 3 years, is being used to recruit practices with a large population that are collecting patient profiling data to the 70% level (the average collection level is 47%), and using this as a basis for research projects. The first year of this work has now been completed.

An extra Computer Facilitator post has been funded for three years, to help practices to get their data collection rates up. The PCT is also looking at how to use this data in its Health Equity Audits; for example one of the doctors in the Public Health Department is looking at how to extract data on hypertension broken down by ethnicity.

During and after this session, the Review Team discussed the success factors, challenges and wider learning that could be gleaned from the IPRP and Datanet projects. These are listed in Section Two.

Service provision and ethnic monitoring

Review Team members met with a small group of PCT staff working in directly provided services in Lambeth, to discuss their views and experiences of ethnic monitoring.

The staff who met with the team were confident that, when working well, the routine collection and use of EM data offers many potential clinical benefits, as well as opportunities to commission and monitor services more effectively. However there are concerns that the purpose and outcomes of EM are not widely understood by LPCT staff and patients, and – as it is neither specifically resourced nor contractually required in most cases - EM is not yet widespread or routine.

The points that follow were identified and described by LPCT staff during their discussion with review team members:

- Services need to know their population, and to see who is actually using services in comparison with the population as a whole and any target group/s. Lambeth is distinctive in its diversity - so recording patients' ethnicity should be core business. EM is already routine for education and the Police; health is perceived to be lagging behind.
- Although laudable, Dr Williams' project has increased perceptions that collecting patient profiling data is 'exotic', difficult, and an optional extra rather than essential. However, although EM itself shouldn't be eligible for enhanced payment, any analytical or strategic work might need to be incentivised.
- SLAs should include a mandatory, enforceable EM requirement, with the data being fed back to the PCT. In this sense it is currently easier to build it into specialist services than core services.
- Ideally, EM information should be collected once and then follow the client between health and social care services – but this proves very difficult in practice.
- The collection of EM information is often misunderstood by patients. For example, some refugees and asylum seekers are concerned about the implications for their immigration

status. Communicating the purpose of EM can be a challenge, and explanatory materials (e.g. about confidentiality) are not available in community languages.

- There is a fundamental issue nationally around definitions of ethnicity. This lack of clarity is unhelpful for frontline staff collecting EM data and undermines its accuracy. For example, some people identify themselves more clearly with their country of origin, religion or language group than their ethnicity, and these can often be confused or collapsed together.
- Although ethnicity can itself be a factor in health inequality, level of deprivation is often much more relevant. However, it is easier to ask about a patient's ethnicity than about their personal circumstances.
- When EM data is collected corporately, it is easier to make the case for resources for specific services or preventative work. However, once the case can be made, commissioning a dedicated service or providing an existing one 'unequally' to redress the balance raises new concerns – particularly if you are already in deficit.
- People can be very anxious around issues of race and diversity, which can become personalised and politicised. This is not helped by statistics around these issues being presented or used in the media in a way that is stigmatising or distorted.
- In this sense, staff may have a very real 'fear barrier' about what could (or should) result from EM; for example if data shows that services are failing some ethnic groups, or the staff profile is less diverse than that of service users. Acknowledging the existence and scale of any weaknesses could lead to concern amongst staff or over-promising to patients. This should not be used as an argument against EM – but needs to be thought about and managed.
- Moreover, there is still a big gap in collective knowledge about how actually to correct health inequalities where they are detected. As an individual's/community's health is so closely related to other factors (e.g. housing or education); what can health services realistically be expected to achieve in isolation? This has implications for investment in services, and - in terms of the 'return' on any investment - for the PCT's credibility.
- The PCT needs to explain the purpose, process, and expected outcomes of EM to all staff. There needs to be clarity about what patient and staff EM data will and will not be used for. If people understand this and what the tangible benefits are, they are more willing to be involved, more inclined to see it as core business and more confident about explaining it to others.
- The relationship/overlap between the PCT's strategic work around health inequalities and its work around diversity (and diversity in relation to HR) is not clear to many staff.

(NB: these points reflect the views of LPCT staff who met with the team, and do not necessarily represent the corporate view.)

Commissioning and ethnic monitoring

Some review Team members met with a small group of PCT staff regarding service commissioning and ethnic monitoring in Lambeth. These representatives were very helpful and generous in the way they shared their understanding of the relationship between ethnic monitoring and the commissioning process in Lambeth. Unfortunately two senior managers and partners were not able to attend the session, and it is possible that a different view might have been articulated had the PCT representatives had more direct experience of the commissioning strategy.

Mental health commissioning

The team was given a briefing on mental health commissioning; lead responsibility for this is with the South London Mental Health Trust (South London and Maudsley NHS Trust, or SLAM) with

whom the PCT has a good working relationship. However, it was reported that Lambeth PCT has some difficulty in accessing the EM data from SLAM that is required to inform its commissioning.

The primary care commissioners and directors decided to undertake a review of talking therapies, and achieved 65% ethnicity recording. This showed a broad coverage of provision (although the services were mostly accessed by women) but identified some potential areas for improvement. This is to lead to a re-commissioning of the service. An overview of the BME needs assessment had been undertaken at the end of last year; unfortunately the report is not yet available.

Other key points from this session were:

- At the moment the discrepancies in health needs are so 'glaringly obvious' that the commissioning team act on this judgement first and foremost - rather than analyse patterns or the take-up of services. It is already known that BME communities are over-represented in mental health services overall, but they may well be under-accessing early onset services.
- The local Acute Trust's (Guys and St Thomas' Hospital) EM data collection coverage is good and improving – at present the rate is 83% and there is a target of 96% by end of next year. This is the first year that the PCT has introduced a target for the collection of data with in its SLA. The Trust is reporting back to Lambeth PCT's board on the percentage of returns they are achieving; however as yet there is no usage of the information and it is not clear if there is any reporting of what the profile reveals.
- The challenge is now to use data to assess need, drawing on both EM and public health data. A training need has been identified for commissioners in the use of data.
- Further, there is still pressure from voluntary groups for more action in response to the needs that are known.
- The Diversity and Equalities group exists within the PCT but is not yet seen to be actually driving the agenda/process. It is also not clear that Race Equality Impact Assessments and the RES are being robustly used within the PCT. Lambeth council have recently started doing some work around this, and there may be an opportunity for joint work.

Human resources, organisational development and ethnic monitoring

Review Team members met with members of the HR department in Lambeth, to discuss their work around ethnic monitoring.

Lambeth is one of the largest PCTs in England and Wales in terms of the size of its workforce, employing around 900 people (over half of whom are clinical staff). This also makes it a sizeable local employer.

Up until 2004 the PCT held staff profiling data for 36% of its workforce. Keen to improve this and to better understand the organisation's ethnic profile, they asked all staff to verify their personal details. A raffle was put on as an incentive, and there was a 90% response rate. This has reduced the "not stated" figure from 36% in July 2004 to 10%. The HR team identified a clear explanation of the reasons behind the data collection as a contributing factor to this success.

Staff ethnic profile

In terms of ethnicity, there is a fairly diverse workforce overall. 44% of staff are from BME groups, although they tend to be concentrated at the lower grades and are significantly underrepresented at senior management level. Recent analysis of ethnicity by pay band has also found that people from some BME groups are more likely to be employed at a senior level than others.

Recruitment and training

Recruitment is now largely done through e-recruitment (EREC), and there is a growing awareness that safeguards will need to be in place to ensure that there is no differential negative impact for applicants from different ethnic groups.

LPCT did record ethnicity data from the recruitment process in the past, however the system used made it difficult to integrate the data and produce comprehensive reports, whilst recruitment monitoring reports were regularly presented to the PCT Board, they did not include information on ethnicity.

Similarly, training data is not presently able to reveal any underlying trends around ethnicity – e.g. the information held at present concerns people receiving training, rather than those who request training and do not receive it.

Lambeth PCT is included in Wave 4 of the Electronic Staff Record (ESR) project, with a “go-live” date of 29th August 2006. Preparation includes extensive data cleansing, and the new system makes provision for effective workforce reporting. This will enable the PCT to get realistic targets to address areas of under-representation.

While the overall dataset is important, the HR team also wants to be able to look at subsets, for example trends within specific teams. Discussion of these issues can otherwise be very subjective.

Staff attitudes

Staff attitude surveys are conducted annually, and these are now forwarded to all staff. The response rate increased from 49% in 2004 to 53% in 2005. Of respondents:

- 86% said there was no discrimination within LPCT;
- 14% said there was discrimination; (of which)
- 10% said the discrimination was racial.

The team heard that some complaints of discrimination had been received, and that these were being treated seriously at a senior level within the PCT. However at the time of the team’s visit it was not clear what action, if any, had resulted.

In February the HR team are planning to pilot HR surgeries. The PCT has also identified and trained staff at various levels of the workforce as Bullying and Harassment support officers, who are intended to provide neutral and confidential support.

Planning is also underway to establish a BME staff group. As well as providing a forum for BME staff to meet and discuss relevant issues, this group could also make an active contribution to the work of the PCT, particularly the equalities agenda.

The review team's findings and recommendations

Overview

Overall, the team was impressed by how far Lambeth PCT has come from where it began on these issues. As well as overall enthusiasm and ambition, examples of specific improvements include:

- Increasing GP involvement in ethnic monitoring
- 80% ethnic monitoring of staff (from a 90% response rate)
- A very useful Health Equity Audit of the borough's Stop Smoking Services

As well as support for:

- Excellent ethnic monitoring rates at the local Acute Trust
- An ethnic monitoring requirement beginning to be included in SLAs – e.g. by the Homeless team

This progress forms an excellent base from which to accelerate. Further, the lessons learned from Dr Richard William's work are invaluable as LPCT takes ethnic monitoring forward across the organisation.

This section outlines the review team's findings – both good practice and areas for further development – and sets out its recommendations for the future.

Implementing ethnic monitoring: learning from IPRP and Datanet

Success factors

- The IPRP questionnaire sent to registered patients is centrally designed, fully funded and accompanied by a freepost envelope. Entering the data from returned questionnaires is also resourced by the PCT.
- Participating practices are simultaneously supported to collect data from newly registering patients, using a standard computer template. Of all the patients asked for ethnicity data in the first year, IPRP practices received less than 10 refusals.
- Once frontline staff are actually undertaking routine EM there doesn't seem to be much resistance to it; education seems to be key to overcoming staff concerns. At its most successful, the process has included the delivery of training to practice and primary healthcare staff, which includes discussion of issues around ethnicity and cultural diversity, and practical tips on how to obtain and use data.
- An extra computer facilitator post is helping to normalise patient profiling work by offering help with this along with more general on-site support to practices.
- Dr Williams and the computer facilitator have visited several practices to talk about the Datanet project – and more generally about ethnicity and health inequalities – which has proven a very valuable exercise. Clinicians often take the attitude that correcting inequalities is to do with larger structural issues, and is mainly the responsibility of Public Health. Dr Williams is able to give concrete examples of where ethnicity and culture are vitally important to clinical practice. Talking about the potential of patient profiling data to improve healthcare is what gets people interested – and this is more effective coming from a 'peer'.

- The standard 16+1 ethnicity codes reflect the main groups migrating to, and settled in the UK, but they can be a blunt instrument (e.g. many people select 'other') and Dr Williams doesn't feel that they give enough information about the structure of communities in Lambeth. The IPRP ethnicity data questions originally used 60 nationality categories chosen with local trusts which could still be re-aggregated up to the standard 16+1. (However management concerns have meant that the dataset has since been changed to match the 16+1 categories more closely, with some additional information recorded.)
- Datanet is following the ethical guidelines used by the MRC – e.g. around anonymously extracted data - and the PCT is producing leaflets about what will be done with data it collects.
- In Lambeth there has been good involvement of the Public Health department with these projects. There is an understanding that there are particular local problems, and Public Health is very keen to start using the data to explore these, and to support the negotiation of appropriate targets.
- Dr William's vision and commitment over a long period of time has clearly been central to the success of IPRP and Datanet.

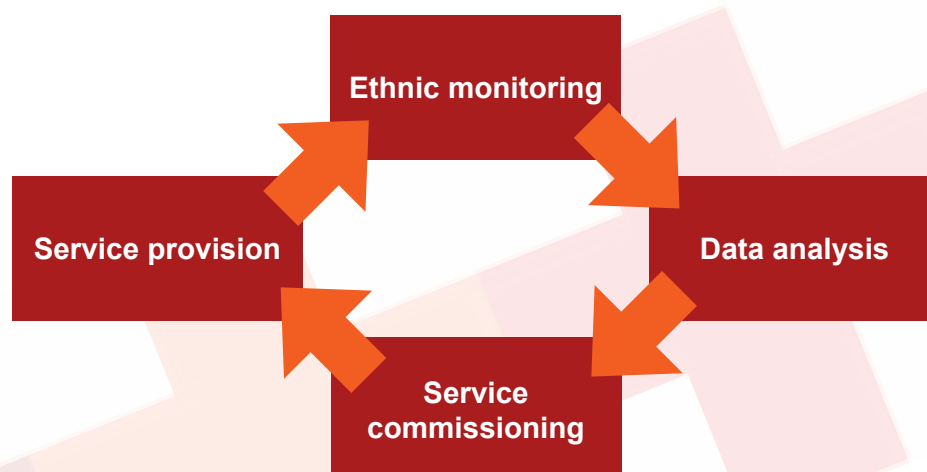
Challenges

- This sort of process requires attention to detail to ensure value for money – e.g. during the second recruitment drive, it was discovered that patient questionnaires had been sent out without a freepost envelope, which dramatically reduces the response rate.
- The patient questionnaire was not translated into a range of community languages (although request slips were enclosed in Spanish and Portuguese).
- One of the problems arising from the IPRP template was the level of specificity possible in terms of coding – there were no nationally agreed Read Codes for nationalities and languages at the time the project began, and there are still gaps/anomalies.
- Ideally everyone would use the same software platform, and data would be held on a single centralised server, so it could be uploaded, accessed and extracted by all. To date there have been many administrative and technical obstacles to achieving this, but the introduction of PAS/RiO should help.
- In the absence of a single system, passing on data is crucial – e.g. referral letters containing information about a patient's need for an interpreter. Standardising letters across practices is hard, but it needs to be more wide-spread.
- List turnover has proved a real challenge. It was thought that the increase in patient profiling would be exponential, but many practices have got to 55% coverage and then 'plateaued'.
- When participating IPRP practices don't get systematic support, some stop collecting EM data altogether. This evidences a general perception of EM as 'extra'; additional to core, routine business. Although the PCT's leadership talked about mainstreaming, their approach to this work to date consists mainly of limited incentivisation – i.e. finding extra money to reward voluntary EM - rather than genuine mainstreaming.
- Similarly, at the moment it is charitable, not mainstream funding supporting the main research work (Datanet) and there is no clear purpose for the remainder of the data collected.
- The national pilot that inspired IPRP was never really rolled out after its initial term expired; it was left to individual's enthusiasm to carry on.
- According to LPCT, It has also been difficult to get user involvement in these projects.

Building on success, capturing the learning

The team suggested the following areas for further work:

- To get the remaining practices on board, and to retain the commitment of existing ones, LPCT is urged to make EM a core requirement, rather than an optional project. Rather than rewards for implementing EM, the PCT should consider sanctions for not doing so. Everyone working in primary care needs to contribute to LPCT's understanding of its population.
- Practice-based commissioning (PBC) could prove to be a useful way to get practices to take EM more seriously, and provide extra leverage for the PCT. PBC will require a change from focusing on people 'presenting', to commissioning services for local populations who need them, whether or not they present. This is a massive cultural change and could see a very positive shift in attitudes toward patient profiling.
- Although it can be problematic, high list turnover should also mean high rates of new registrations. LPCT should give attention to analysing the pattern of turnover and developing appropriate strategies for undertaking EM of both the static population and more mobile elements. Engaging 'hard to reach' patients is a common problem, but the team did not detect a strategy or any target-setting around these groups.
- However, focusing too much on completion can give the impression that EM is seen as an end in itself. It is concerning that practices are being asked to be part of such a big project - requiring a substantial investment of time - without any clear short or medium term results/outcomes. It is good to do special research projects (e.g. through Datanet) – but the use of patient profiling data needs to be more routine than this.
- To avoid it seeming a bureaucratic exercise, well-publicised, tangible outcomes are key – i.e. systematic data analysis and, ultimately, substantive input into commissioning. In the meantime the PCT should also try to build on existing experience in terms of practices using their data themselves; e.g. one practice has used their data to figure out which of their patients were at risk of vitamin D deficiency.
- LPCT may need to reframe the question: this is not just about collecting ethnicity data, but about how issues of race equality are addressed in commissioning and service delivery. Different strands of work on this theme can be found throughout the organisation, but they need to be pulled together and the links made explicit. The importance of systematically collecting 'softer', qualitative EM information should be emphasised as part of this.
- If LPCT is to really move this work forward, it should see EM as part of a larger process, where each link is vital to ensuring that the others function optimally. Specifically: EM produces a data resource, and the analysis of this data informs service commissioning. Both the analysis itself and its use in commissioning reinforce the practice of EM. The services commissioned should better reflect the population and patients' needs, and usage is then monitored by the service through collection of EM data. This 'virtuous circle' is illustrated in the diagram below:



- Without all of the links in the chain operational at once, the effectiveness of EM - and the motivation of staff and patients to undertake it - is considerably reduced. Accordingly, although good practice in any one area is an excellent start, it will only be embedded with simultaneous improvement in the other areas.
- LPCT's leadership are in a position to be able to take this overview, and ensure that their intentions are communicated and implemented throughout the organisation. The Health Inequalities and Diversity Steering Group should play a key role in driving this work. This group should also take steps to ensure there is more clarity around its role generally; that its remit and responsibilities are widely understood and its links into the organisation sufficient and robust.
- At the moment it is unclear whether the commitment to race equality at the top of the organisation has been communicated to the staff as a whole; e.g. why EM is relevant, important, and what, if any, change it might lead to. Training and/or awareness-raising events for all staff should be run systematically, including in LPCT's own directly managed services. It is clear that these make a real difference to EM being understood, accepted and properly implemented at the frontline. LPCT is fortunate in having some excellent practice and learning to be able to share with staff (particularly from IPRP and Datanet).
- When implementing EM in healthcare, there are likely to be difficult implications – e.g. around stigmatisation, possible service decommissioning, and the PCT's staff profile. Because it is seen as such a complex, politicised issue it becomes more daunting - but this shouldn't be used as an excuse for stasis.
- The team suggests setting 'process' targets for EM data collection and using available data in the PCT's next round of contract negotiations. Targets could include:
 - Improving data collection in GP services;
 - Improving data collection in provider services; and
 - Improving the use of all data.
- There is a good business case to be made for reducing inequality in healthcare – in particular, appropriate and adequate primary care provision for BME people decreases their use of secondary and tertiary services. Cost reductions could be achieved by analysing these pathways – which requires routine EM.
- It is then up to LPCT to ensure that its commissioners are willing and able to use EM information and analysis (quantitative and qualitative) and can show that this has happened. This is a challenge for everybody, but it is critical to making 'Commissioning a Patient-led NHS' work.
- The population data resource generated by EM could also be of value beyond the NHS. Accordingly, LPCT may be able to tap into other sources of funding, e.g. from the local authority and other statutory partners.

The points below concern the areas of HR and organisational development specifically, and accordingly have been listed separately.

HR and organisational development

The team were impressed by:

- The HR team is clearly committed and progress is being made around EM of staff - there are some instances of very good practice (e.g. gaining good response rates for staff surveys).
- The HR team is aware of the deficiencies of the old recording system, and are thinking about how the new system will build on the current one.
- Overall, the HR team is neither defensive or complacent, and open to suggestions for improvement.

The team suggested the following areas for further work:

- Although collecting and reporting staff profiles, the HR team don't seem to be doing much analysis of these, or setting any targets as a result.
- The new systems being put in place may address this. However, there is a danger of taking this forward quite conceptually, focusing on the technical issues more than the potential pitfalls in practice and how to mitigate them. For example, EREC was introduced prior to consideration of the potential differential impact on certain BME groups.
- If EM data establishes that the organisation doesn't reflect the community, LPCT needs to properly think through the interventions it puts in place, and communicate the purpose, nature and expected outcomes of these very clearly to staff.
- The HR department itself comprises six people, the majority of whom are white (five out of six). During recruitment, the panel that candidates see has been shown to affect their performance in an interview. LPCT should create a more mixed panel, getting outside assistance in finding suitable panellists if necessary.
- During recruitment, HR currently records why a candidate was not selected (e.g. the selected candidate had more experience). This is different from recording whether a candidate was 'appointable', which is essential information to capture if HR is to answer queries on discrimination within the recruitment process.
- As a whole, the LPCT recruitment process would benefit from a Race Equality Impact Assessment to ensure any potential for disadvantage is identified and mitigated.

The review team believes that the current operating environment for PCTs - while challenging - also offers an opportunity to improve on current practice and implement change.

In Lambeth, '*Commissioning a Patient-led NHS*' offers an opportunity to ensure that ethnic monitoring plays a key role in future service commissioning. Lambeth PCT's commendable commitment, optimism and forward momentum around race equality in general should also be maintained.

The Peer Review Team

Margaret Adjaye

Equality and Diversity Manager, Wandsworth PCT and St Georges Health Care Trust

Margaret has been the full time Equality and Diversity Manager for Wandsworth PCT since April 2004. Since 1st December 2005, her post became shared with St Georges' Health Care Trust, where she works directly with the Director of Operations to ensure that clinical services and organisational activities promote equality of opportunity for all. Margaret's background is in Training and in HR Relationship Management and she has worked with several private and voluntary sector organisations, in the UK and abroad, such as Standard Chartered Bank, Maternity Alliance and Mercury Communications.

Jonathan Barnwell

Assistant Director, Refugees, Race and Health, Haringey Teaching PCT

Jonathan has been at Haringey TPCT since November 2002. A part of the Public Health Directorate, Jonathan is the deputy lead on Trust policy relating to race equality and refugee communities in Haringey. He is also the lead on NHS programmes for refugee doctors in North Central London. Previous positions include head of international affairs at the Royal College of Physicians. Academic interests are primarily in the field of social epidemiology.

Brian Colman

Equalities and Diversity Manager, WPCT

Brian has been in his current post at Westminster PCT since June 2004. He began his career as a local authority social worker before moving into community development work and then service planning in social services, with an increasing emphasis on voluntary sector capacity building and equalities. For two years until May 2004, Brian was sponsored by the Department of Health to work at the Commission for Racial Equality as the joint national lead on health and social care.

Helen Hally

National Director, Race for Health

Helen is a nurse and a psychotherapist, and has worked in a variety of clinical, educational and managerial roles. In addition, she has been involved in a range of performance review and policy development initiatives, from the development of a national strategy on women's mental health to public inquiries into homicides. Before her appointment as Race for Health's new Programme Director in July 2005, Professor Helen Hally was Director of Nursing at Haringey Teaching PCT.

Paul Jeff

Senior Project Officer, Department of Health

Paul Jeff joined the Department of Health's Equality & Human Rights Group (EHRG) on 28 November 2005. He is a Senior Project Officer with an interest in the Pacesetters and Race for Health Programmes. From 2000 to 2005, Paul worked in a variety of posts within the Department of Health and the Department for Education and Skills on children's social care. These included policy development on raising the educational attainment of looked-after children. For the past 2½ years, Paul has been working on the development of regulations and guidance as part of the work programme to implement the Adoption and Children Act 2002.

Neelam Kumar

Non Executive Director, Ealing PCT

Neelam has been a Non executive Director of Ealing Primary Care Trust since its inception. Prior to that, she was a Non Executive Director of Hillingdon Health Authority and West London Healthcare Trust, and a Mental Health Act Manager. She has a special interest in Diversity and Health improvement issues, and has worked as an Independent Consultant for 25 years developing software to model public transport systems.

Charles Lauder

Thinking Partner, Lambeth PCT

Charles is Director of Talawa Consulting, a company that designs and delivers client-specific management development and diversity consultancy. Recent work has included the design and delivery of a diversity and inclusion strategy for the London Development Agency. Charles is also Vice-Chair of Culture Northwest – the Cultural Consortium for England's North West - and a Board member of Greater Manchester Courts Board.

Habib Naqvi

Public Health Analyst, Bristol Public Health Directorate

Habib Naqvi joined the NHS in 2000 as a Research Associate examining ethnic differences in the equity of access to primary care coronary heart disease services. In addition, he is involved in a range of specialist research and practice initiatives, including the evaluation of a communication tool-book for patients who speak little or no English, assisting in the management of the Bristol South Asian Community Diabetes Facilitator Project, and aiding the implementation process of patient profiling across the Bristol PCTs. In his current post of Public Health Analyst, Habib is also leading on Health Equity Audit work.

Vicky Walker

Locality Support Officer, Bristol North PCT

Vicky is new to the NHS, joining in May 2005 as a Locality Support Officer. In this role, she is working with dental and GP practices within the Inner City and East of Bristol North who are providing services to a diverse and highly deprived area. Vicky has been working with practices on a number of projects, and in November 2005 she became the lead for the patient profiling project for Bristol North PCT. Prior to this Vicky has worked in a variety of public sector services including Social Services and the Probation Service.

Shared Intelligence

Race for Health Learning Programme Advisors

Sue Charteris

Director, Shared Intelligence

Sue is a senior public policy consultant specialising in local government and public service reform, and is a founding director of Shared Intelligence (Si). She has a wealth of expertise in strategy and policy development, organisational development and knowledge exchange, and leads many of Si's learning network programmes.

Rebekah Brumwell

Consultant, Shared Intelligence

Rebekah works as a consultant and project manager, and has particular expertise in supporting peer reviews. Most recently, Rebekah worked on prototype peer reviews of the Museums, Libraries and Archives Council and Arts Council England on behalf of DCMS.

Tendai Pasipanodya

Consultant, Shared Intelligence

Tendai has recently joined Shared Intelligence as a consultant, and has been working on research and global trends mapping. Tendai completed an MSc in Development Studies at the London School of Economics in 2005.