



race for health



LIVERPOOL PCT PEER REVIEW

22-23 January 2008

Outcome Paper

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1. INTRODUCTION

The review

- 1.1. Liverpool PCT hosted a Race for Health (RfH) Peer Review on 22nd and 23rd January 2008. Peer reviews are used within the programme to share learning and good practice between PCTs, and support the host PCT to identify areas of improvement and actions that could be taken to address them.
- 1.2. Liverpool PCT was formed in October 2006 (following the merger of North, South and Central Liverpool PCTs) and joined the RfH programme in 2007. It was therefore an excellent opportunity for the review team to visit the PCT, particularly in the year that the city has been named European Capital of Culture. The peer review offered the chance to consider the city's history, particularly its role in the slave trade with a visit to the International Slavery Museum, to understand how this impacts on people's lives in Liverpool today.
- 1.3. The review focused on mental health, and in particular how the needs of the Black and Other Racial Minorities (BRM)¹ population are being met. A number of existing initiatives were drawn on to explore the issue and the potential ways of influencing future commissioning decisions.
- 1.4. The purpose of this paper is to highlight the issues that were covered during the course of the review, and present the main findings and recommendations from the peer review team.

Key questions

- 1.5. The key questions posed by the PCT for the review were as follows:

- To what extent can **Patient Profiling** in its current form support health needs assessment **to inform commissioning decisions**, and can the barriers it encounters be overcome?
- How can **other methods of recording ethnicity**, e.g. through QOF and hospital patient monitoring (and other indicators of diversity), complement Patient Profiling and inform commissioning?
- How can **GP practice based disease registers** be used to establish health needs across a range of conditions, and support monitoring of the RfH Performance Indicators?
- How can the role of the **Community Development Workers** complement health needs assessment and improve the access of BRM communities to mainstream mental health services?
- How has this work helped the PCT to **meet the needs of BRM service users with depression and severe mental illness** more effectively, and what further improvements could the PCT make?

¹ This terminology has recently been adopted by the PCT following feedback and discussion at a community event.

2. BACKGROUND AND CONTEXT

Liverpool PCT

- 2.1. Liverpool PCT is a Spearhead PCT with a budget of over £800 million. It was formed in October 2006 by the merging of three former PCTs - Central Liverpool Primary Care Trust, and North and South Liverpool Primary Care Trusts.
- 2.2. Liverpool PCT has set out ambitious plans for new and improved primary care facilities, delivering enhanced services through an expansion of community-based healthcare within the next seven years. *A New Health Service for Liverpool* sets out Liverpool PCT's commitment to provide:
 - more and better services in the community, so people only go to hospital when absolutely necessary;
 - major investment to improve existing health facilities and to build new centres;
 - improved access to healthcare, with extended opening hours and more patient-centred appointment systems;
 - services in locations that are accessible by public transport and core services within a 15 minute walk for everyone in the city; and
 - investment in more community-based doctors, nurses and other health professionals joined-up health services, bringing together more professionals in one location.
- 2.3. As well as having a strong provider arm, the PCT has a very strong commissioning ethos and strives to be a world class commissioner in all that it does. This will become a primary focus when the provider and commissioning roles split, with the provider arm planned to become a Foundation Trust.

Liverpool

- 2.4. The profile of Liverpool has changed dramatically since the 2001 Census, making the planning of services a real challenge. The latest figures put the population at 436,100 (source: 2005 mid year population estimates) and while the city is known for its vibrant and diverse community, it actually has a smaller proportion of non-White people within its population than England as a whole (7.7% in Liverpool compared with 11.9% nationally).
- 2.5. For example, Liverpool's Black population – though small – is the longest established Black community in the UK. The city also has increasing numbers of Yemenis, Somalis and Caribbean communities. Although some Somalis have arrived fairly recently, due to the long-running unrest in Somalia, there are older communities dating back from when Somaliland was a British protectorate more than a century ago, when young sailors were enlisted there to serve on British naval ships as they toured the globe.
- 2.6. Liverpool is also well known for its large Irish population. Although relatively few people (approx 5,000) identified themselves as being of Irish origin in the 2001

Census, nearly a third of the city's population is believed to have some Irish ancestry. Less well-known is its vibrant Chinese community (approx 6,800 people), which can trace its origins to the arrival of a few hundred Chinese seamen to work on the docks in the 1800s. Liverpool is also home to one of the highest concentrations of mixed-race people in England. One in nine residents within the Princes Park electoral ward are mixed race according to the 2001 Census – the highest proportion of any such local area in the country.

- 2.7. Since 1998, Liverpool has become a nominated city for the dispersal of asylum seekers. The city receives a number of individuals and families on a daily basis residing in the city while their claim for asylum is decided. Exact numbers are difficult to estimate as the Home Office is unable to give figures, and as Liverpool is only one of three cities in the UK with an Immigration Office, there are a number of other groups that will migrate to the city with a multitude immigration status.
- 2.8. In addition to this, the city has seen, like most others across the UK, an increase in Eastern European communities. Many are attracted by the city's history of hospitality to overseas communities, and many have families and friends that arrived as asylum seekers before May 2004. They also recognise the ability to access employment opportunities and local services in the city. Many of the communities have taken ownership of properties which were previously known as 'hard to let' and a number are entering the 'buy to let' housing market. This has seen the creation of neighborhoods with noted infrastructures developing such as Polish supermarkets.
- 2.9. The detailed breakdown of the population by ethnicity is shown in the table below; a map showing the distribution by ward can be found in appendix one.

Residential Population Statistics by Ethnicity (percentage)

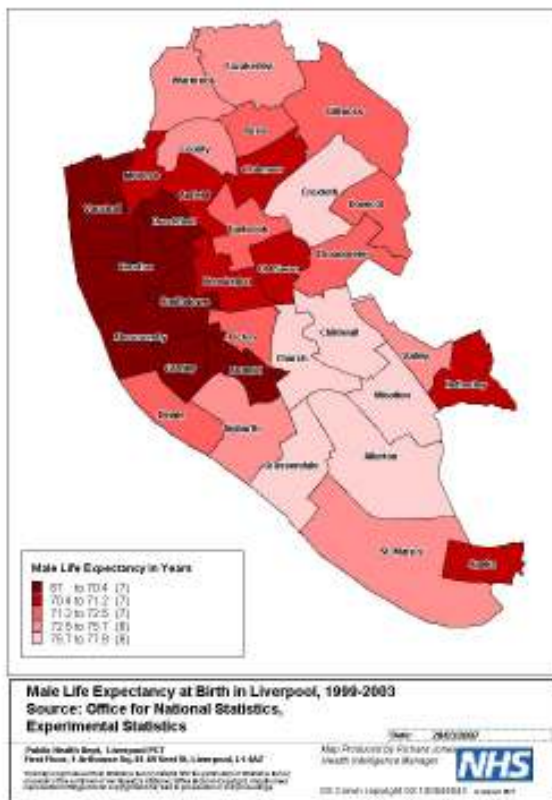
| Ethnic Group | Liverpool | North West | England |
|-------------------------------------|------------------|-------------------|----------------|
| White | 92.3 | 92.9 | 89.1 |
| of which White Irish | 1.1 | 1.1 | 1.2 |
| Mixed | 1.9 | 1.9 | 1.6 |
| Asian or Asian British | 1.9 | 4.1 | 5.3 |
| Indian | 0.8 | 1.3 | 2.4 |
| Pakistani | 0.3 | 2.0 | 1.6 |
| Bangladeshi | 0.2 | 0.5 | 0.6 |
| Other Asian | 0.5 | 0.3 | 0.6 |
| Black or Black British | 1.8 | 1.0 | 2.7 |
| Caribbean | 0.3 | 0.4 | 1.2 |
| African | 1.2 | 0.5 | 1.3 |
| Black | 0.3 | 0.1 | 0.2 |
| Chinese / Other Ethnic Group | 2.1 | 0.9 | 1.3 |

Sources: 2005 Mid Year Estimate, ONS, LPHIT
 NB: Figures may not sum due to rounding

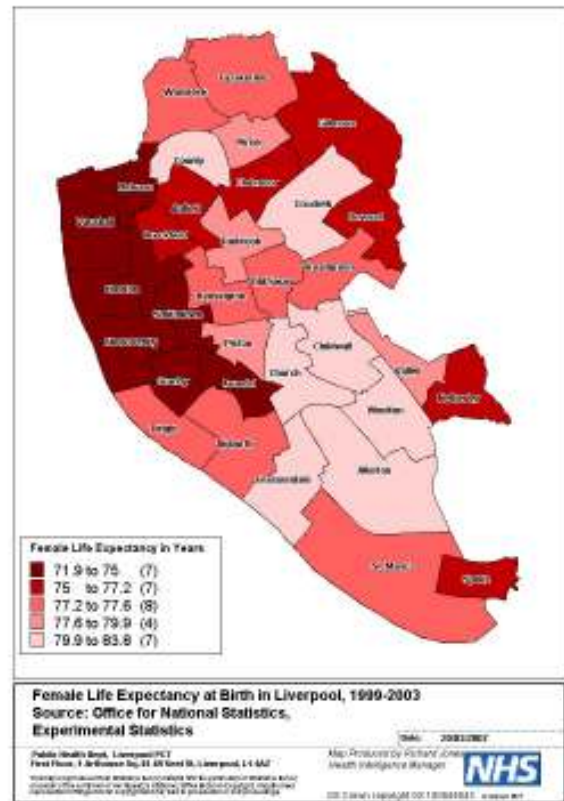
Health inequalities

- 2.10. Inequalities in health continue to be an issue in Liverpool as they are in the rest of the country. Although life expectancy, for example, has risen in recent years to an average of 73.8 for males and 78.3 for females, the gap between the most deprived and most affluent areas has not narrowed (source: ONS 2006 and LPHIT). For instance, Woolton ward has the highest male life expectancy of 77.9 years, compared with 67 years in Smithdown ward. Similarly, female life expectancy ranges from 83.8 years in Childwall to 71.9 years in Everton. This can be seen in the maps below, which show male and female life expectancy across Liverpool's wards. Life expectancy increases the lighter the shading.

Male Life Expectancy



Female Life Expectancy



Promoting equality and diversity

- 2.11. Equality and Diversity for Liverpool PCT is about promoting health equalities for all groups and communities in the city by identifying and overcoming barriers to access and inclusion across the range of health services and practices. This means a service that is fair, flexible, engaged and responsive to cultural, physical or social difference.
- 2.12. The PCT's vision is to be a champion and leader in promoting equality, managing diversity and challenging discrimination. Equality and diversity has played a pivotal role in the three former organisations and will continue to do so in the new, merged PCT. There is a strong commissioning emphasis and a clear focus on involving patients and staff in primary health care delivery. In recognition of the positive outcomes in service delivery and employment practices that the current Equality

Diversity team have delivered, the PCT has created a senior specialist post within the commissioning arm – Head of Diversity Equality – that will be charged with continuing the momentum of positive change into the new organisation by enabling transparency, consistency, accountability and user engagement in procurement arrangements.

The Equality and Diversity Sub-Committee

- 2.13. Equality and diversity activity is overseen by the Equality and Diversity Sub-Committee, a sub-group of the Trust HR Committee (a Committee of the Trust Board) that reports on activity and actions on a quarterly basis. The sub-committee provides a forum to support the PCT in promoting equitable working practices and access to services for all users. Core membership of the group includes Non-Executive Director representatives, the Equalities Team, Service and HR Managers from across the full spectrum of PCT functions, and representatives from the Diversity Staff Networks. It is chaired by the Chair of Liverpool PCT, Gideon Ben-Tovim, who has also recently accepted a position of Vice Chair for the RfH programme.
- 2.14. The Equality Diversity Sub-Committee is charged with:
- developing a Strategy and Action Plan based on the requirements of the equality and diversity agenda;
 - ensuring that Equality Schemes take account of the wider aspects of inclusion and meet the business plan of Liverpool PCT;
 - overseeing the implementation and development of the Equality and Diversity Agenda of the Trust, including delivery on action plan targets on an annual basis;
 - supporting the implementation of action plans in a strategic manner;
 - reporting resource implications both in financial and human terms;
 - sharing good practice, monitoring progress and championing change relating to Equality and Diversity Action plans; and
 - monitoring the work and contributions of staff networks.
- 2.15. The RfH agenda and the progress of Liverpool PCT against the performance indicators is a regular item for discussion and review at Equality Diversity Sub-Group meetings. Members receive an overview of the current position in relation to achievements and measurable outcomes for BRM staff and service users, identify further priorities, specify targets and key actions to deliver improvements, and designate ownership and responsibility at directorate level.
- 2.16. Additionally, the development of Equality and Diversity principles and respective activity under the RfH programme is a regular item on the HR Committee Business Agenda, and thereby is fed back directly to the Executive Board on a quarterly basis. The Board itself receives a full and comprehensive overview report of all equality and diversity activity and progress for Liverpool PCT via a dedicated meeting that is repeated annually.

Development and consultation of the Race Equality Scheme

- 2.17. Established links with local BRM communities, in addition to the Black staff network (more details below), have proved invaluable for the development and consultation on the recently updated Race Equality Scheme (RES). The PCT has used its longstanding and positive relations with local BRM communities to facilitate consultation and engagement, and has also recruited bi-lingual advocacy and link workers to bridge the gap between health care professionals and non-English speaking communities.
- 2.18. Prior to the development of the new RES, both staff and users were given opportunities to provide feedback on outcomes and achievements from previous RES activity, and identify areas which they felt required further priority consideration. Comments were sought from staff via the staff network meetings and to capture those who may not attend, all staff were informed of the PCT's plans to review and revise the race equality work via the electronic staff bulletin. They were also invited to comment by emailing the Equality and Diversity team. The PCT published a draft RES on the internal and external website in November 2007 to provide opportunities for further comment prior to final endorsement by the Trust Board in December 2007².

Workforce

- 2.19. The PCT employs a total of 2,840 people. The Director of HR covers both Liverpool PCT and Royal Liverpool and Broadgreen Hospital Trust, covering in excess of 11,000 employees. The makeup of the workforce is summarised below.

Ethnicity of staff

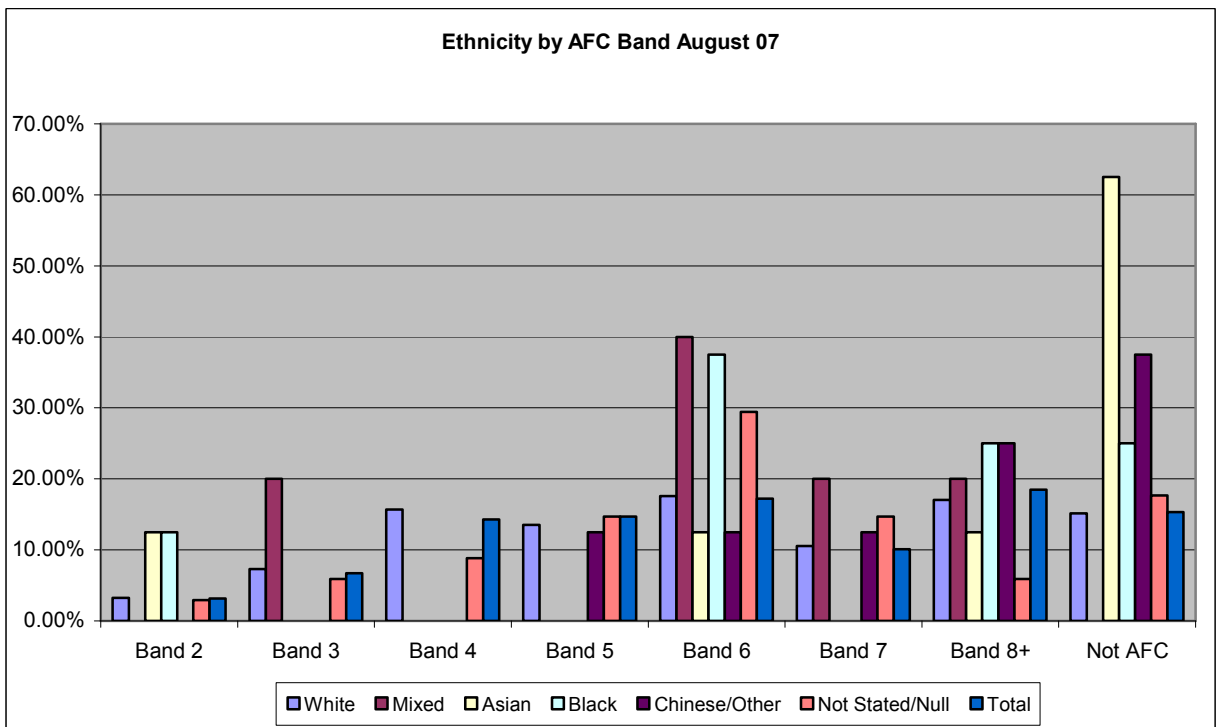
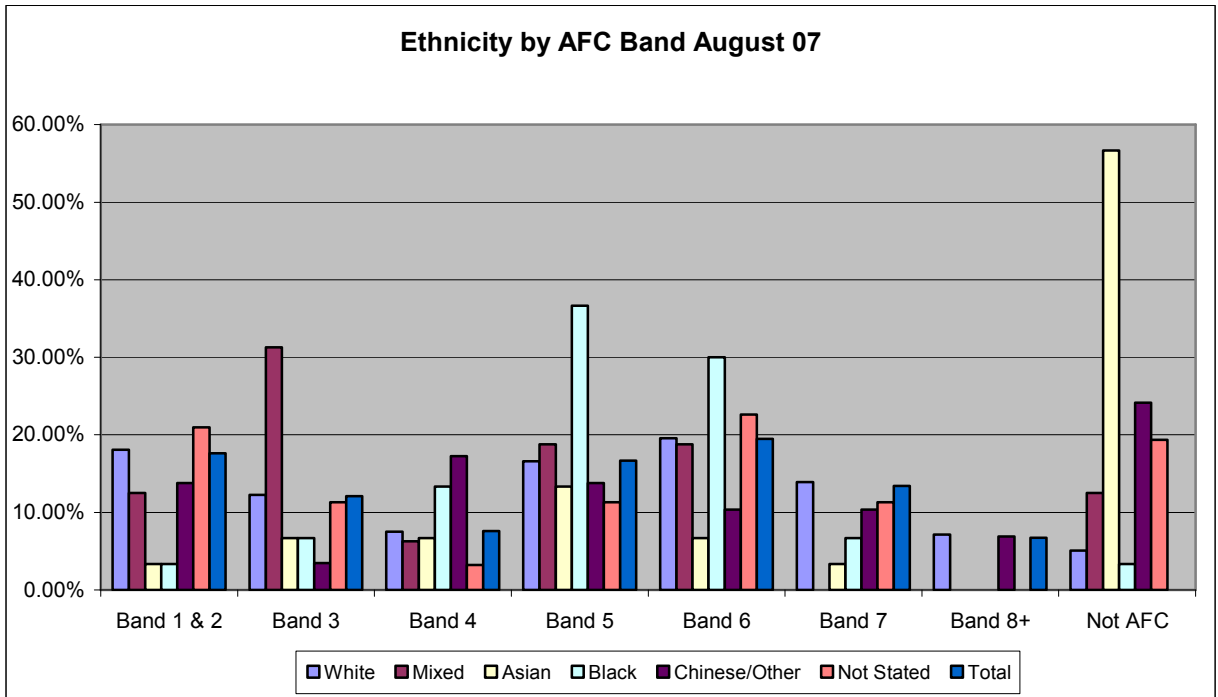
| Ethnic Group | Number of Staff | Liverpool PCT | Liverpool Area | Merseyside Area |
|---------------------|-----------------|---------------|----------------|-----------------|
| White | 2593 | 91.30% | 94.30% | 97.13% |
| Mixed | 24 | 0.85% | 1.80% | 0.97% |
| Asian/Asian British | 39 | 1.37% | 1.10% | 0.62% |
| Black/Black British | 40 | 1.41% | 1.20% | 0.50% |
| Chinese & Other | 37 | 1.30% | 1.60% | 0.78% |
| Not Stated/Null | 107 | 3.77% | - | - |

| Ethnic Group | Number of Staff | Liverpool PCT | Liverpool Area | Merseyside Area |
|-----------------|-----------------|---------------|----------------|-----------------|
| White | 2593 | 91.30% | 94.30% | 97.13% |
| Non white | 140 | 4.93% | 5.70% | 2.87% |
| Not Stated/Null | 107 | 3.77% | - | - |

Source: Liverpool PCT

² A copy of the document is available at www.liverpoolpct.nhs.uk/Library/Publications/Equality/RaceEqualityScheme.pdf.

2.20. Ethnicity by Agenda for Change (AFC) band is a way of considering how different BRM groups are distributed across the bands. The breakdown by AFC band for both provider and commissioner services can be found in the chart below.



Black Staff Network

2.21. The Black Staff Network is city-wide, covering all NHS organisations in Liverpool. The network has regular meetings, awareness days and workshops for the 70 members it has on its register. It is there to help individuals with any difficulties they are

experiencing in work, particularly in terms of discrimination and harassment, and to mediate for members where necessary. Members feel that there are still problems with people from BRM communities who are not achieving in the NHS so the network acts as a support mechanism for them. The network members think more detailed staff profiles should be developed, showing length of service and grade.

- 2.22. The network is open to all staff, not just those from BRM communities. This means that membership includes a number of White staff. Equality and diversity staff also attend the meetings and recently held an equality and diversity study day for the network members.
- 2.23. Members feel that while the network gets a lot of backing from the senior levels of the PCT, it needs to raise its profile significantly within the organisation. Also, up until now, the network has not received any funding. A recent bid for funding for training and administration has been approved, however, and will cover other networks, such as the LGBT and disability networks.

3. THE FOCUS OF THE REVIEW: MENTAL HEALTH

Introduction

3.1. The inequalities and disengagement with services experienced by BRM communities with mental health needs is well documented and a high priority for action across the country, as evidenced by the Department of Health Delivering Race Equality in Mental Health five-year action plan. At a local level, Liverpool PCT has sought to actively promote this agenda in the following ways:

- The PCT has recently become a **Focussed Implementation Site** building on the experiences of their buddy site Manchester. The Strategic Health Authority covering Cheshire and Merseyside seeks to adopt a collaborative and multi-agency approach to implement race equality in mental health, pioneering best practice to deliver on the commitments of the DRE action plan.
- The PCT has also recently appointed a team of seven **Community Development Workers** to progress and review performance on implementation of DRE across Liverpool through direct community engagement, appropriate services development and improved access to relevant and timely information. The workers (two of whom are based in community organisations) will identify key priorities and adopt a three-year strategic response to addressing inequalities in access, outcome and experience for BRM mental health service users.
- The PCT has begun to create robust and accurate **monitoring systems** to ensure the local mental health register accurately reflects data for BRM service users, and that this information informs local plans and activities in relation to services development and improvement.

3.2. In view of these developments, the PCT felt it was both appropriate and timely that this peer review focused on the plans and achievements of the Trust towards eliminating discrimination in mental health services. While the PCT is proud to share the progress made to date, staff are nevertheless aware that this is an increasingly evolving agenda which is likely to grow as the DRE programme changes and develops over time, and hence will require sustained commitment and progress to ensure plans and achievements are incorporated and embedded into mainstream activity.

Mental health improvement

3.3. The North Mersey Mental Health Improvement Plan (MHIP) describes a ten year vision for the mental health and well being of the populations of Liverpool, Sefton and Knowsley.

3.4. Ninety per cent of people with mental health problems are treated solely in primary care. Primary care manages the spectrum of mental health problems, including those people with severe and complex issues. People from BRM backgrounds are less likely to be referred to specialist services from primary care and access mental health services generally.

- 3.5. In line with 'Our Health, Our Care, Our Say', the MHIP focused on the need to shift the emphasis away from hospital based systems of institutionalised care to more appropriate, inclusive and effective alternatives in community settings. Mental health wellbeing is also an important policy theme, hence the requirement to improve access to psychological therapies and interventions which promote this aim. These issues are central to the MHIP and a contestability exercise is currently underway to ensure delivery of a new and enhanced psychological therapy service across North Mersey.
- 3.6. Access to and choice of mental health services are important policy themes. Poor experience in relation to accessing mental health services is common. Accident & Emergency Departments are often a first point of contact for individuals, which can result in multiple 'false starts' in treatment. For BRM communities, there is an over representation of people who present through the criminal justice system and/or are detained in hospital as a result of poor access to and limited choice of services.
- 3.7. The key themes underpinning the MHIP therefore are as follows:
- to develop services which promote positive mental health, reduce inequalities and promote inclusion for disenfranchised groups, including people from BRM communities;
 - to strengthen primary care services with a focus on improved and equitable access to an extended range of interventions which reflect the needs of diverse communities; and
 - to ensure that specialist mental health services intervene early and effectively in the treatment of psychosis to support optimum recovery.

Integrated Commissioning Framework

- 3.8. Liverpool has responded to the National Commissioning Framework for Health and Well-being, published in March 2007 for consultation, by producing an Integrated Commissioning Framework for Health and Well-being. Key features of the local framework include:
- making sure the PCT commissions services that are based on the needs of people using them and their carers;
 - developing clearer policies for commissioning;
 - keeping up to date with changes in legislation and new national and local initiatives;
 - supporting acute and primary care commissioning and procurement processes;
 - supporting multi-disciplinary project management; and
 - co-coordinating the production of three year commissioning strategies which includes mental health.
- 3.9. In order to support this work, the PCT is spearheading an innovative approach that integrates health and social care. As such, a Joint Director of Integrated Health and Social Care and Commissioning has been appointed to work with the PCT and the City Council and an integrated commissioning unit has been established to take on

cross cutting issues such as diversity, equality, social inclusion, regeneration, human rights and engagement and consultation. The integrated structure will enable the PCT and Local Authority to make a speedy and unified response to local and national priorities. The unit has already established considerable networks with other statutory organisations and with the voluntary and private sectors.

Mental Health Equity Audit

- 3.10. The Merseyside Mental Health Equity Audit was undertaken by Liverpool Public Health Observatory in 2004 on behalf of the Directors of Public Health of Primary Care Trusts (PCTs) within Merseyside. The aim was to examine equity in access to services and mental health needs of residents of the PCTs, using 'readily available' performance measures. It was the first time such work had been attempted, and involved exploring the feasibility of mental health equity audit. The PCT is clear that it should be regarded as a baseline study, and it is proposed to renew the audit during 2008.
- 3.11. The findings confirm that there are problems of access to primary care for ethnic minority groups, which may result in a greater likelihood of developing acute mental health problems. The Merseyside HEA revealed that around 1 in 6 of all adults reported some form of neurotic disorder. In Liverpool, the rate was 1 in 4, higher than both the regional and national figures.
- 3.12. Prevalence rates were higher among women than men. This was true for most age groups, except among those aged 45-49. There was a prevalence of neurotic disorder in 1 in every 3 females in Liverpool – over 60% above the national rate. South Asian and 'other' adults had higher rates of prevalence for most neurotic disorders than their white counterparts, while Black adults appeared to have lower rates.
- 3.13. The prevalence rate for psychotic disorder was 5 per 1,000, with a concentration of cases amongst those aged 30-44. Prevalence of psychosis among Black people was more than three times greater than among white people. There is also evidence that Black people in Merseyside are over-represented among those under section of the Mental Health Act and those on CPA (Care Programme Approach).
- 3.14. However there were gaps in the data for breakdowns by ethnicity and where ethnic group was recorded, there were large proportions of 'not stated'. This means that the method of recording ethnicity data is currently a public health and commissioning priority for improvement.
- 3.15. An audit of four General Practices was conducted which piloted a method to correlate patient data from GP Serious Mental Health Registers with data from Patient Profiling. Patient Profiling has been long established in a significant number of Liverpool General Practices and involves collecting a range of information for all patients including ethnicity, spoken and read language, and religion. This allowed the PCT to compare prevalence of three mental health conditions (schizophrenia, bipolar disorder and other psychosis) among BRM patients with all patients on GP Mental Health Registers. The PCT was able to draw tentative conclusions about prevalence, as well as the robustness of the data used and its usefulness to inform commissioning of services for BRM communities. The ability to audit GP Disease Registers in this

way will also support monitoring and reporting against Race for Health Key Performance Indicators.

Liverpool Mental Health Consortium

- 3.16. Liverpool Mental Health Consortium was established in 1995 and is a service user-led organisation. Membership includes people with direct experience of mental ill health, their friends and families, and groups, organisations and services that aim to support their needs across all sectors. The Consortium's aims are:
- to promote partnership working at a strategic level;
 - to maximise service user influence; and
 - to improve the quality of services from the point of view of the people who use them.
- 3.17. In 2004-2005 Liverpool Mental Health Consortium organised a series of stakeholder events on behalf of Liverpool's Local Implementation Team (LIT). The events were used to establish the priorities of the broad range of local stakeholders as represented by its membership. Each event was attended by between 50 and 80 stakeholders, and all revealed a richness of experience, ideas and aspirations.
- 3.18. One of the events was dedicated to finding ways of making social inclusion and recovery approaches central to the planning, commissioning and delivery of services. It had input from local service users, champions of recovery, and national lead on mental health and social inclusion from National Institute of Mental Health – England (NIMHE). The Liverpool Joint Commissioning Group has confirmed its intention to continue supporting the Consortium due to the success of the stakeholder events.

Community Development Workers (Mental Health)

- 3.19. The PCT has recently appointed a team of Community Development Workers (Mental Health) who will help to tackle racial inequalities in the way people from BRM communities in Liverpool access and experience mental health services.
- 3.20. In order to tackle these inequalities effectively, the PCT and the CDWs have realised that it is important to know what services currently exist, what could be provided and what gaps there are in provision. The CDWs are therefore currently conducting a mapping of mental health services for BRM communities in Liverpool to ascertain the level of service provision and how services are provided in the statutory and voluntary sectors. The mapping will assist both commissioners and providers to identify gaps and priorities in the provision of mental health services for BRM communities.
- 3.21. The mapping document was sent to a wide cross-section of around 200 statutory, voluntary and private sector organisations involved in the provision of mental health services in Liverpool. The mapping exercise was initially scheduled to run over five weeks in September/October 2007 so that the findings could be presented at a launch event – Delivering Race Equality in Mental Health Care in Liverpool – in November 2007. It was hoped that the report would provide a rich context for the conference workshops which were to be used to identify priorities to guide the work of CDWs in

Liverpool. Responses to the mapping exercise were not, however, as the CDWs would have hoped, having received only 17 completed documents by the time of the conference. Since then, responses have been coming in more quickly and the CDWs are offering support where necessary with completing the documents.

- 3.22. Commissioners within the PCT recognise the importance of the work that the CDWs are doing. The CDWs will be working closely with the commissioners to support the commissioning of services that meet the needs of BRM communities in Liverpool. The commissioners and the CDWs have agreed on ways to strengthen this process and ensure that the work of the CDWs influences commissioning and the tendering process. These include the following:
- the senior CDW will attend the monthly meetings of the Joint Commissioning Group (JCG) for Adult Mental Health;
 - the CDW team will have bi-monthly meetings with the commissioners to allow the CDW to feedback to the commissioners and for both teams to raise any relevant issues;
 - the CDW team will offer training to the commissioning teams on the needs of specific BRM communities and groups; and
 - the senior CDW team will sit on panels to evaluate service specifications and how bidders propose to meet these.
- 3.23. The CDW team will continue with the mapping of services, while developing work plans that reflect the priorities outlined in DRE as well as those identified by the local stakeholders.

Mary Seacole House and the Advocacy Project

- 3.24. Mary Seacole House and the Advocacy Project are part of and governed by Granby Community Mental Health Group. Both projects provide services primarily for people from BRM communities who suffer from mental illness, and while they are both located in Mary Seacole House, they are separate projects delivering separate services.
- 3.25. The primary role of Mary Seacole House has been to provide a day centre service for people with mental health needs within BRM communities. Before this service was set up, it was identified that people from BRM communities were not accessing mainstream mental health services and their needs were therefore not being met. Staff at Mary Seacole House say that this was because they did not trust mainstream services and that these services were not culturally sensitive. Mental health is viewed very differently among many BRM communities and it was felt that mainstream services were not addressing this appropriately.
- 3.26. As such, Mary Seacole House was set up in 1991 to provide the support that the mainstream services were lacking. Over the last 16 years, the work there has progressed significantly and Mary Seacole House now delivers an outreach service for carers and a floating support service that allows workers to care for people in their own homes. Staff from Mary Seacole House have also provided training to other providers in the area on cultural sensitivity, race and mental health, and language

barriers. This has included staff from Windsor House, a 24-bedded residential mental health unit (see below).

- 3.27. At present, Mary Seacole House is supporting around 95 people through its day centre and floating support services, and a further 35 carers through the outreach service. There is no waiting list for the service; membership is sustained by agreeing a 2-day, 3-day or 5-day membership based on need. This means that there are usually around 25 people at Mary Seacole House every day. Referrals are made through a number of channels, including GP practices, Community Psychiatric Nurses and occupational therapists. Funding for Mary Seacole House is primarily through Liverpool City Council, who has responsibility for adult social services under joint commissioning.
- 3.28. A couple of years after Mary Seacole House was set up, staff began to realise that a formal model of mental health advocacy was needed, particularly for BRM communities. In 1993, funding was granted from the City Council to set up an Advocacy Project that aims to raise awareness of the difficulties people from BRM communities face in the mental health system. Since then additional funding has been provided by the PCT for this service and Comic Relief has provided funding for a Peer Advocacy Training Programme. This is a 12-week training programme for advocacy support workers, followed by a placement scheme. At present however, the project has been unable to offer any employment opportunities following the programme.

Windsor House

- 3.29. Windsor House provides an acute in-patient ward for adults with severe mental health problems as part of a wider acute in-patient service provided by Mersey Care NHS Trust. It has two separate wings, allowing for separate male and female wards. It serves the local community and wider community, having been in operation for over 10 years. The staff, in particular, thought that the location of the facility in the heart of the community enabled families to visit more easily.
- 3.30. One of the six Community Mental Health Teams (CMHTs) that work across Liverpool is based within the unit. The CMHT aims to promote recovery, prevent relapse and encourage social inclusion, providing a specialist mental health service to the population. They work in partnership with other services and agencies to ensure effective service is given to those in need. The CMHT is a multi-disciplinary team (MDT), comprising Doctors, Nurses, Social Workers, Occupational Therapists and Psychologists, who have a range of skills to cover the needs of all clients.
- 3.31. Windsor House also has close links with GP practices and the local police, with the majority of referrals coming through the GPs and the City Council's care line. Although the facility has been operating under some physical constraints, the review team was told that capital provision has been made to improve the facility.

4. KEY FINDINGS

- 4.1. This section of the report details the peer review team's findings. Specific findings on each of the areas covered through the field visits are covered in detail, followed by the more general, overview findings regarding the PCT's approach and progress.

Black staff network

- 4.2. The peer review team felt that the Black staff network was **very well integrated** across Liverpool, covering the whole health economy not just the PCT. This provides an opportunity to link in directly with other organisations and partners across Liverpool. The team felt that this was an asset and that the PCT might want to consider making the network independent of all those organisations when the commissioner and provider arms of the PCT split.
- 4.3. The team felt that the network had very **clear values, strong commitment and good leadership**; the fact that members knew exactly where they wanted the network to go in future came through very strongly. This was backed up with good publicity to communicate those aspirations clearly, as well as high level support from both the Chief Executive and Chair of the PCT.
- 4.4. Activities undertaken by and within the network were very broad and included, for example, mediation and capacity building, and delivery of education and training on equality and diversity within staff inductions. Future aspirations ranged from providing more individual support to having a greater input in policy development. In order to meet some of these aspirations, members of the network recognised the **need for better information and knowledge** within the PCT and the way it could be used to develop decisions. This might include data from the staff survey on satisfaction rates and the staff profile.
- 4.5. The team was pleased to hear that the network was one of three that had recently been awarded some **funding**. The funding will be used across the three networks, covering race, disability and LGBT (lesbian, gay, bi-sexual and transgender) issues. The peer review team thought that this funding could potentially strengthen the role of the network, perhaps helping it to become a stronger resource for the PCT through the empowerment of its members.
- 4.6. Members of the network were aware that membership was fairly low and had already come up with some encouraging suggestions for attracting more members. However, the team picked up a concern that although the network had senior level support, there was **sometimes a lack of commitment from line managers** in encouraging staff to join the network. The team felt that it would be useful to look at why that might be and how it can be changed.

Community Development Workers

- 4.7. The peer review team was very impressed with the Community Development Workers (CDWs), who they thought were extremely **aspirational**, with **a very clear focus** on mental health and BRM communities and what they wanted to achieve.

- 4.8. Moreover, as a team, the CDWs had **a real range of skills** at a high level between them. These included, for example, experience and knowledge in advocacy, IT and community activism. The team thought it was very useful to be able to draw on these skills where needed.
- 4.9. The team was glad to see that the CDWs have been working on mapping existing services and improving patient profiling across Liverpool. This work should be enhanced by closer working with the Patient Profiling and Public Health Intelligence teams, to combine audits carried out within GP practices with CDW needs assessments. The team also felt that **more analysis of this data** would be useful for those at the strategic and operational levels, so that commissioning is supported by a detailed understanding of the population, services and needs. Although this process is happening at present, the team felt that the PCT should look at the balance of these three strands and perhaps do more work around needs assessments.
- 4.10. Moreover, it was clear to the team that the CDWs are working in partnership with and are well linked into a range of organisations across Liverpool, and have obvious **experience in consultation and engagement**. Although the PCT has seen consultation and engagement as part of the CDW role, the CDWs suggested to the team that the PCT could make more use of these skills.

Mary Seacole House and the Advocacy Project

- 4.11. Members of the team who visited Mary Seacole House and the Advocacy Project thought that the two projects were delivering an excellent service that was **unique** in its approach and **culturally sensitive** nature. Both services deal with individuals that statutory services are unable to reach, fulfilling a role that other providers in the area are not. An indicator of the projects' success is the sheer amount of calls and referrals they get from across the city and outside.
- 4.12. However, in spite of this, staff at both these projects voiced **concerns around funding and sustainability**, and were insecure about their relationship with the PCT and the City Council. In particular, the review team picked up some concerns about the new tendering system being introduced and what this would mean for their future. While the team was told by the PCT that there was a sustainable programme of funding for Mary Seacole House, uncertainties among staff at Mary Seacole House were clearly evident. The team therefore felt that the messages being sent out by the PCT had not necessarily removed the misgivings and fears among the staff at Mary Seacole House, even though there were potential opportunities to be gained through the new system for voluntary organisations in Liverpool.
- 4.13. Although the PCT has reassured the projects that funding will not be an issue for them, these messages did not seem to be being received in the way they were intended and the team felt that more work could be done to **strengthen this relationship**. Moreover, the PCT might want to look at how it can offer support to Mary Seacole House and other BRM and third sector providers in the tendering process.
- 4.14. The team also felt that the resources and knowledge of staff at Mary Seacole House were not being used as well as they could be. Staff have developed **detailed specialist knowledge of local communities and their mental health needs**, and

monitor all ethnic data on their members, so the team felt that the PCT could make more use of this knowledge and experience to inform their decision making.

- 4.15. In addition to this, a successful peer advocacy project has been developed but has struggled to find employment opportunities for participants at the end of the course. If the PCT and City Council worked more closely with the Advocacy Project on this, they could **look at ways of expanding and supporting the service**.

Windsor House

- 4.16. Members of the review team who visited Windsor House were impressed with the level of **commitment among staff** and the impact this had on the community. The unit is clearly **valued by local people and community groups**, who understand the facility and why it is there. This meant that no stigma is attached to it and it is well regarded.
- 4.17. The team also thought that Windsor House provided a **personalised approach** to care, due to its small size, and that it had strong operational frameworks and good principles and values, particularly in terms of cultural sensitivity. They were impressed with the outreach work with GP practices and the unit's links with the police, schools, colleges and universities.
- 4.18. However, members of the team who visited Windsor House were expecting to see patients mainly from BRM communities, when in fact many of the patients there at the time of the visit were White and admissions data over the last six months showed that the majority of new admissions were White British and there had been no Black African admissions over that period. The team was unsure whether this was due to the referral system for the unit, since it only take referrals from GP practices and not everyone is registered with a GP, or whether needs within the population had changed. It might also have been that patients from BRM communities access this kind of care in other more specialised units, so the patients the team saw were not representative of the system overall. In light of this finding, the team thought that the PCT might want **redefine and re-state what this service is and what needs it is meeting** in order to clarify its role.
- 4.19. This also relates to concerns raised by staff at Windsor House about the **impact of the new asylum dispersal points on services** in the city. Staff said that it is difficult for them to provide those communities with services and a real nervousness within those communities to access services in the first place, which they felt the PCT needs to consider. Following the review, the team was told that the PCT is currently working on a specific health needs assessment of asylum seekers which will be completed by the end of March 2008.

Overview

- 4.20. All the team were very impressed with the **strong sense of vision and values** at the top of the organisation; it was clear to the team that the PCT knows where it wants to go and there is **a lot of energy** to make this happen. What was not so clear, however, was how that is being filtered down the organisation and out to partners. It struck the team that the Board and Senior Management Team is moving very fast and has a future-focused strategy, knowing where it wants to get to and how, but that it needs to

be careful that it is not moving too fast for others to keep up. The PCT needs to make sure it is bringing everyone on the ground along with it too.

- 4.21. The team also felt that there was **a strong commitment to Liverpool** within the PCT and other organisations that were visited during the course of the review. The team got a sense that people were, and certainly felt, part of the community they were serving. The team thought that was a real strength and the only downside of it might be that there is the potential not to look outside the organisation or the city for new thinking and ideas.
- 4.22. In addition to this, it was clear during the review that the PCT has **a really strong commitment to equality and diversity**, which has been demonstrated with the appointment of a Head of Equality and Diversity. There were some question marks for the team over where the equality and diversity sub-committee was placed in the organisation; at the moment, the sub-committee sits within and reports to Human Resources, which the team felt missed the link between equality and diversity issues and services. Therefore the team thought that the PCT might want to **consider where that sub-committee sits within the PCT structure**, and was pleased to hear that discussions around this have already been happening.
- 4.23. The team thought that the PCT was brave to admit that its challenge was not resources, presenting a good but challenging opportunity for its top team. In particular, the team felt there was **significant potential in the integrated commissioning system** and felt that the joint appointment of the Director for Integrated Health and Social Care and Commissioning was a very innovative approach. The team was keen to see how this new approach progresses and what benefits it brings.
- 4.24. In particular, the team felt that one way of improving commissioning through this new system would be to **work more closely with third sector providers, particularly BRM providers**. The team met with some excellent BRM providers, and felt that strengthening relationships with these providers and others across the city would be crucial in becoming a world class commissioner. Those providers need to understand how and why decisions are made, and can offer valuable knowledge and insights into the needs of the communities the PCT serves. The team was pleased to hear that the PCT intends to find ways of getting BRM and other third sector providers more involved in the commissioning process to capture this knowledge and creativity. Following the review, the team also learned that commissioners have developed a quality incentive scheme which includes incentives around the collation of information relating to BRM communities.
- 4.25. All members of the team were impressed with the amount of data collection there had been to support this and agreed with Liverpool PCT colleagues that **more analysis now needs to be done to turn that data into intelligence**. There is also an issue about completing that loop, so that the intelligence is constantly being fed back to the PCT and its partners.
- 4.26. Moreover, while the team was **impressed with the level of patient and public involvement** that had been undertaken across the city, there were some questions about how these views are balanced with need. For example, if the PCT decided that changes to the services offered by Windsor House were required, it should work with the local community to agree how the facility could be better to used to meet their needs.

5. RECOMMENDATIONS

- 5.1. This section outlines the peer review team's recommendations for Liverpool PCT based on the key findings. It covers specific recommendations relating to the areas covered through the field visits and general recommendations relating to the PCT's approach.

Black staff network

- 5.2. The peer review team thought the PCT should develop better data and knowledge on workforce and work with closely the Black staff network on what the data means and how it can be used more effectively.
- 5.3. In addition to this, the team thought the impact and success of the network could be improved if the PCT could look at why line managers are not encouraging staff to join the network and work with them to explore how this issue can be resolved.

Community Development Workers

- 5.4. Based on the work of the Community Development Workers, the peer review team thought that the PCT should look at extending the work on auditing patient profiling data, building on the work already done through the mental health equity audit. This will give a clearer picture of the needs of the communities.
- 5.5. In addition to this, the team thought that the PCT could work with the CDWs to look at more ways of utilising their experience in consultation and engagement. They are well placed to be able to carry out this kind of work effectively, so the PCT should think about it can best draw on this resource.

Mary Seacole House and the Advocacy Project

- 5.6. The peer review team felt strongly that the PCT should strengthen its relationship with Mary Seacole House and other BRM and third sector providers to dispel their fears and concerns over funding. More dialogue and communication is needed to reassure them of their future.
- 5.7. In line with this, the PCT should offer support to Mary Seacole House and other BRM and third sector providers on the procurement and commissioning process, to achieve its place as a world class commissioner. This support is necessary if the PCT wishes to retain a wide variety of providers that meet the needs of different communities.
- 5.8. The peer review team also thought that the PCT should make more use of the specialist knowledge and experience among the staff at Mary Seacole House and the Advocacy Project, as well as other BRM and third sector providers across the city. This knowledge and experience is particularly valuable early on in the commissioning process when assessing needs and deciding on priorities.

- 5.9. In addition to this, the team would like to recommend that the PCT thinks about how it can work with the peer advocacy project at Mary Seacole House to secure more employment opportunities to participants at the end of their course. This would really help to maximise the success of the project and build on the opportunities that it creates.

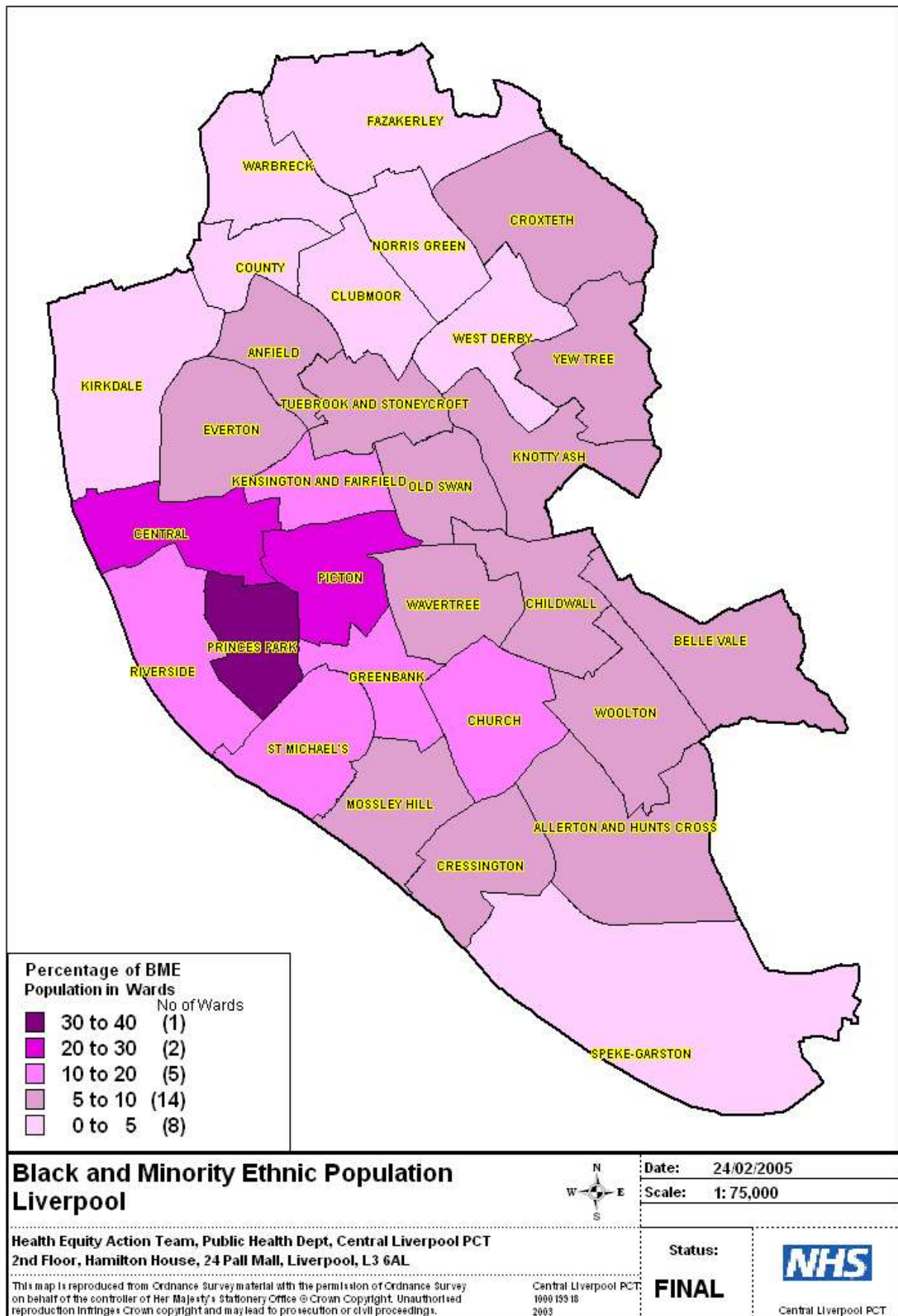
Windsor House

- 5.10. Members of the peer review team who visited Windsor House thought that the PCT should consider re-stating and redefining this service, in terms of what the service is, who it is for and what needs it is meeting.
- 5.11. Feedback from the staff at Windsor House suggested that, if this is not already being done, the PCT should explore the effect of the new asylum dispersal points on services like this and take appropriate action.

General

- 5.12. The fast pace of the PCT's top team is impressive, but the peer review team saw a real need for the PCT to ensure partners and others on the ground are being brought along too. These two levels need to be working together, and communication is crucial in achieving that.
- 5.13. The peer review team also agreed with the need to consider the most appropriate place and reporting arrangement for the Equality and Diversity sub-committee within the PCT's structure, thinking about its relationship with both services and workforce issues.
- 5.14. The team would also recommend, in line with the PCT's own thinking, that more analysis of available data is carried out to turn that data into intelligence. The amount of data that has been collected is impressive but work now needs to be done to use that information in a meaningful way.
- 5.15. Furthermore, the team felt there was a need to balance consultation and engagement with rigorous needs assessment, so that decisions around commissioning are made with a detailed understanding of the population, its needs and current services. The PCT should do further work with Merseycare NHS Trust around how it collates information about BRM communities and how their needs are met through services in (or as close to as possible) their local community.

Appendix 1: Distribution of resident BRM population in Liverpool



Appendix 2: Peer Review Team

Leo Atkins

Head of Teaching Programme, Haringey TPCT

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Joint Director of Public Health, Ealing PCT

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Head of Diversity, Haringey TPCT

Scott Durairaj

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Professor Helen Hally

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Appendix 3: Liverpool PCT Participants

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Margaret Thomson

Head of Public Health-Business Planning, Liverpool PCT

Michelle Cox, Andrea Derbyshire, Surya Shaffi and Frank Davidson

Equality and Diversity Team, Liverpool PCT

Debbie Nixon, Rachel Plant, Catherine Reynolds and Lorraine Hodgkinson

Mental Health Commissioning Team

Ann Keenan

And other colleagues within the Social Inclusion Team

Donna Robinson

And other staff at MerseyCare NHS Trust

Staff at Princes Park Health Centre, Abercromby Health Centre, The Elms, Brownlow Hill Group Practice who enabled the use of their practice data.

Thanks also to the staff and service users/members of the Mary Seacole House, Advocacy Project and Windsor House, as well as the Community Development Workers (Mental Health) and members of the Black Staff Network who participated in the review.

The team would like to send their condolences to the colleagues and family of Surya Shaffi, who sadly passed away shortly after the review took place. Surya was an inspirational member of the equality and diversity team, and was responsible for significantly advancing the PCT's work on disability issues.

Appendix 4: 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.