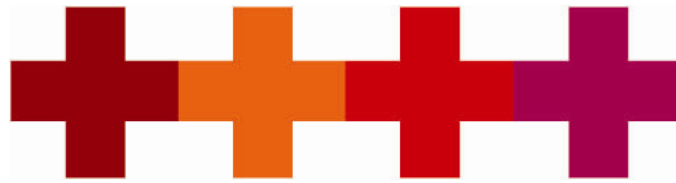


# race for health



a transformational change programme

## South Birmingham PCT Peer Review

28 February – 1 March 2007

### Outcome Paper

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## Executive Summary

1. On 28<sup>th</sup> February and 1<sup>st</sup> March 2007, South Birmingham PCT hosted a Race for Health (RfH) Peer Review to examine its current work around the development and delivery of a new 'para-professional' workforce.
2. Para-professionals are support workers trained to an accredited standard to work alongside communities and professionals in a range of health and community settings. Their development is based on past difficulties in recruiting BME communities in the NHS and poor experiences of accessing services among disadvantaged communities. Moreover, new demands on family support services meant that there was a real skills shortage.
3. The review sought to explore how the development of the para-professional workforce has benefited local communities, particularly those from BME groups, and how the role has made an impact on different services and particularly on the development of the PCT's approach to practice based commissioning.

### KEY FINDINGS

- The peer review team was very **impressed with the level of commitment** exhibited by South Birmingham PCT in relation to its work around the development of the para-professional workforce. The team felt it had made real progress, despite some major changes within the PCT itself.
- The team felt the PCT had developed **a more sophisticated view of demography and a strong enthusiasm to pilot new and innovative ways of working** and improving service delivery, which should be commended.
- One of the overriding concerns of the team was that while they saw some very good examples of the impact of the para-professionals in a range of settings, they were unclear how the PCT intended to **evidence this impact**. This was a major concern not only to satisfy funding requirements and to provide evidence for future funding bids, but for the PCT to understand what does and doesn't work, to improve the projects in future.
- In addition to this, the peer review team was unclear how much **community involvement** there had been in the development of new models and delivery, and agreed that local communities and service users should be an essential part of any future evaluative activities. This is a good way of understanding the needs of local communities and their experiences of the new services.
- An important point picked up by the review team was that it appeared that **many para-professionals were graduates** who were finding it difficult to access employment in the NHS. There were concerns among the team that many of these graduates may be from BME backgrounds, presenting some real issues around recruitment.

## RECOMMENDATIONS

- The peer review team was impressed with the development of data on demographics and health profiles within South Birmingham, and would recommend building on this work and **using the data more systematically**.
- The team felt that more work needs to be done around **evidencing the PCT's achievements**; it was good to see how far the PCT had progressed but the team felt that valuable learning will be lost if the PCT does not make a stronger commitment to gathering evidence on impact and what works.
- A strong aspect of this evidence gathering needs to focus on **community involvement** – the PCT should consider more ways of involving local communities and service users to better understand how services and the recent changes to them have benefited them, what other barriers to access still remain, and how services can be improved in future.
- The peer review team felt that the PCT's RfH work had become more focused over the last year, but would recommend it being brought more in line with the overall race equality agenda of the PCT so that **a strategic focus** is kept. Given that the PCT has recently reviewed the Race Equality Scheme and has started developing ownership of the action plan, now seems like a perfect opportunity to ensure Race for Health is an integral part of that agenda.
- Given the issues around the **qualification level of the para-professional workforce**, the peer review team would like to recommend that the PCT and Gateway Family Services take into account what proportion of the trainees are graduates from BME backgrounds. If the proportion is high, the PCT and Gateway Family Services may wish to consider whether a more structural approach is needed to tackle some of the bigger issues around race inequalities in recruitment within South Birmingham, and whether these issues could be brought up with the Local Strategic Partnership in recognition of a wider problem across the area.

# 1. Introduction and theme for the review

## The review

- 1.1. South Birmingham Primary Care Trust (PCT) hosted a Race for Health (RfH) Peer Review on 28th February and 1st March 2007. The review focused on the work currently being undertaken by South Birmingham PCT to develop and implement the delivery of a new 'para-professional' workforce – support workers trained to work in a range of health and community settings.
- 1.2. The review explored the reasons behind the development of the workforce and how the programme might benefit local communities, particularly those from BME groups. The review team was also given the opportunity to see how the role had been applied in different settings, in order to understand more fully what impact the workers are having on different services.

## Key questions

- 1.3. The peer review aimed to explore the following questions:

- **Will the use of a para-professional workforce bridge the gap between marginalised BME communities and general practice? What evidence is there that this is beginning to have an effect? What are the benefits and challenges of this approach?**
- Has the development of para-professionals led to an increase in knowledge regarding the needs of marginalised BME communities in South Birmingham?
- What impact has this 'new knowledge' had in the provision and development of health services provided to children and families?
- Can this 'new knowledge' be used to inform practice based commissioning so more culturally appropriate services are provided?

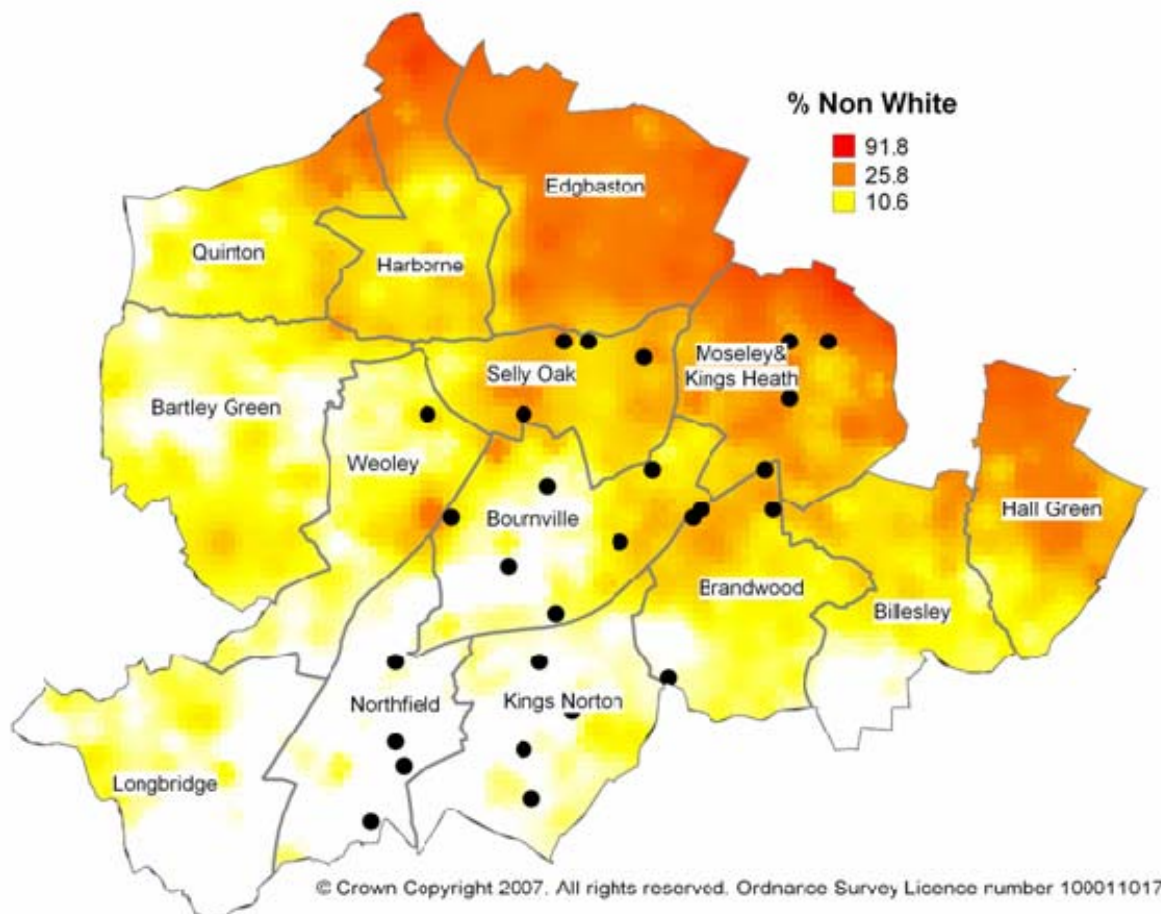
## The outcome paper

- 1.4. The purpose of this paper is to outline the work that was examined during the course of the review and present the main findings and recommendations highlighted by the peer review team on the day.

## 2. Background and context

### Demography and inequality

- 2.1. Birmingham is a city undergoing significant change to its demographics and the distribution of population. Perhaps most significantly, the BME population within the city is increasing at a very rapid pace and it is projected that the city will have a majority BME population within the next 10-15 years.
- 2.2. This increase is leading to out-migration from the inner city, as new immigrant communities cluster in the inner-city wards – areas where highest risk and poorest health outcomes are usually found. This can be seen in the map below, which shows the area covered by South Birmingham PCT and the concentration of non-white groups on the edge of the inner city area.



- 2.3. In many ways this is not a complex phenomenon; the Birmingham inner-city is physically full to capacity and growth in BME communities continues. Historically, the Irish community went through the same process 25 years ago, as their community grew and as new immigrants took their place as the residents of inner-city Birmingham. But while the phenomenon is simple to understand, the implications are significantly less well understood and less well explored. For example, the pattern of out-migration and the changing populations will have a significant impact on practice based commissioning in South Birmingham.

## Health profile

- 2.4. The three biggest causes of death in South Birmingham are diseases of the circulatory system, cancers and respiratory systems failures. The average outcomes for South Birmingham residents compare well with those for England, but this disguises significant and long-standing variations across the area. Over 100,000 people live with long-term health conditions, and these are unevenly distributed; twice as many people are affected in poor communities as compared with the most affluent areas. Deprivation also affects life expectancy; there is an eight year average difference in life expectancy between the most deprived and most affluent communities. This impact also relates to a wider range of outcomes, for example in learning and employment.
- 2.5. Following the 2001 census, it is projected that just over 20% of South Birmingham residents are from BME groups, but this does not account for residents of Irish descent, where poor health outcomes show significant persistence across generations. As highlighted above, out-migration has led to higher levels of BME groups in the population of some wards and a clear correlation with deprivation. However, the exact impact of this change in the population is not completely clear by any means.

## South Birmingham PCT

- 2.6. South Birmingham PCT is one of three (previously four) PCTs covering the city of Birmingham. In addition to its role as a commissioner of services for the South Birmingham population, the PCT also contains a number of specialist provider services that cover the whole of Birmingham, including learning difficulties, children specialist services, district nursing, elderly care services, physical rehabilitation and a dental hospital.
- 2.7. As part of the response to wider changes in the NHS, South Birmingham PCT is working with its provider arm to deliver a separate provider organisation, as a Community Foundation Trust. This will allow South Birmingham PCT to explore new ways of meeting the needs of local communities and to focus more clearly on the challenge of increasing access and utilisation of community health services.

## South Birmingham Health Economy

- 2.8. In addition to the community health services delivered by the PCT provider arm, the main acute services provider is University Hospitals Birmingham (UHB), a first wave Foundation Trust. Part of UHB incorporates an A&E service based on the site in the Selly Oak Ward.

- 2.9. Specialist services are provided by the Royal Orthopaedic Hospital, Birmingham Women's Hospital (Maternity Services), Birmingham and Solihull Mental Health Trust, and Birmingham Children's Hospital. These specialist providers have city and regional specialisms as part of their service offer.
- 2.10. South Birmingham PCT is moving forwards with the development of practice based commissioning based on four clusters. In total there are 276 GPs operating out of 64 surgeries. The vast majority of GPs in South Birmingham are group practices. This contrasts sharply with the other two PCT areas, which still have high numbers of single-handed practices. In addition, there are 51 optometry practices, 85 community pharmacies and 70 general dental practices.
- 2.11. The PCT has recently appointed a new Director of Strategy and Commissioning and they are clear that they need to be commissioning services for the population – this means meeting the needs of all people in the community within available resources.

*'We need to get much more sophisticated in how we commission services that respond to needs, wishes, beliefs, and culture of different individuals... Practice based commissioning is important because people really understand their population at that local level.'*

## **The Race Equality Scheme**

- 2.12. South Birmingham PCT has found that access to the RfH programme has been a valuable way of taking a serious look at what they have done in their Race Equality Scheme (RES). The PCT took the opportunity to review their RES and decided that a single equality scheme is not right for the organisation at this time. They feel they still have a lot to do in terms of race equality and now realise that they need to make the RES 'live'. This includes establishing an accountability framework and having recently appointed a new set of Directors in new roles, the PCT has been looking to link equalities accountabilities to their portfolios as Executive Directors.

### 3. The current Race for Health Focus

#### The development of a para-professional workforce

- 3.1. South Birmingham PCT has a long history of involvement in the development of a para-professional workforce. One of the key drivers behind the work has been a failure to recruit from BME communities, particularly at the middle manager level. At the same time, new demands on family support services meant that there was a real skills shortage and a lack of recognition of what the appropriate skills were. Moreover, evidence highlighted poor experiences of accessing services and a lack of educational outcomes among disadvantaged communities.
- 3.2. In order to address these issues, South Birmingham has developed the role of para-professionals – support workers trained to an accredited standard who work alongside communities and professionals in a wide range of settings. To date, these have included community nursing teams, special schools, Child Development Centres, Sure Start programmes, and Primary Care teams.

#### Application of the role

- 3.3. Children's services were an early adopter of the para-professional model, being employed by the PCTs and the local authority in Birmingham from 2003 and funded through mainstream sources. Para-professionals in children's settings mainly report to Children Centre Managers and Children Family Support Workers. There are approximately 55 para-professional Community Family Workers employed in Children's Centres, Primary Care teams and children's specialist services across Birmingham. A further 33 trainee Community Family Workers are employed in Children's Centres. Last year, 67% of the trainee workers and students were from a BME background.
- 3.4. Most recently, the para-professional model has been used in two Neighbourhood Renewal Funded<sup>1</sup> (NRF) projects – the Healthy Heart Programme and the Pregnancy Outreach Worker Programme – to tackle infant and male mortality across the areas of the city most affected by poor health outcomes. The Healthy Heart project started in October 2006 and will be funded for the next two years. It employs 18 para-professionals, the majority of whom are employed on a full-time basis. Six of them are of Pakistani origin, four are Indian, one is Irish and the remaining six are White British. These workers came into post in January 2007 and the total cost for the project is £600,000.
- 3.5. The Pregnancy Outreach Worker Project started in January 2007 and will also run for two years. It aims to employ 28 workers,

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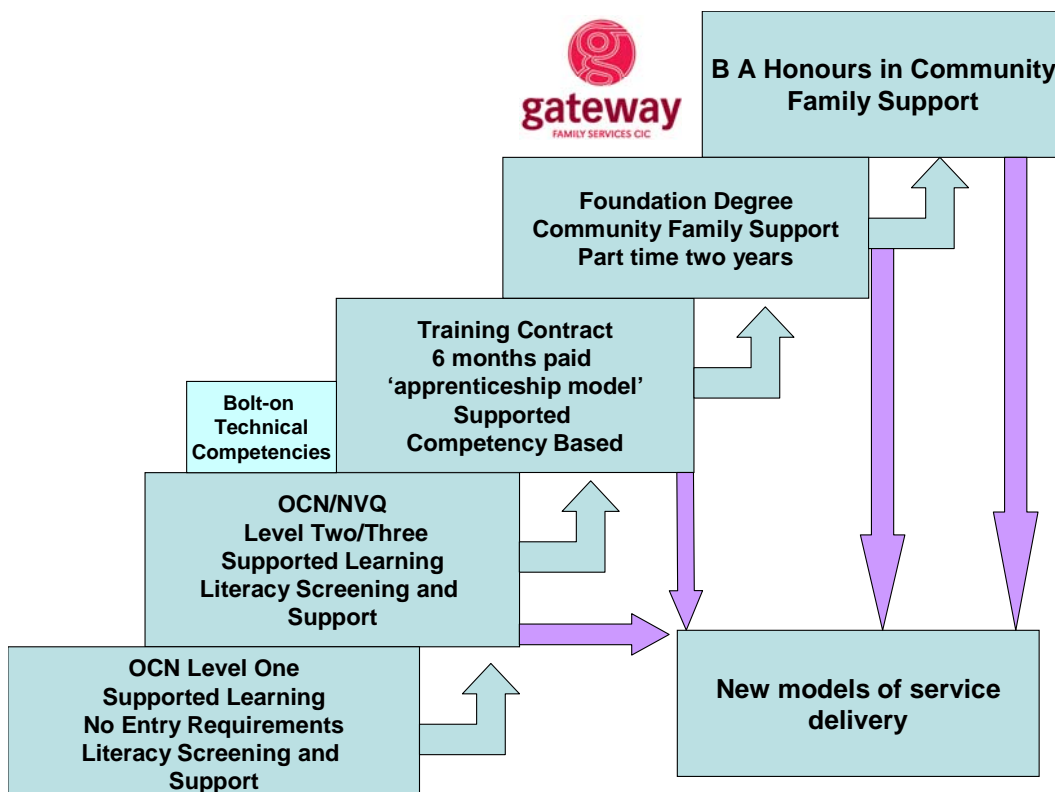
<sup>1</sup> The Neighbourhood Renewal Fund (NRF) aims to enable England's most deprived local authorities, in collaboration with their Local Strategic Partnership (LSP), to improve services, narrowing the gap between deprived areas in the rest of the country.

many of whom will be employed on a part-time basis. The interviews for these positions took place in the week beginning 12<sup>th</sup> February 2007. The total cost of this project is £800,000.

- 3.6. The para-professionals employed in both these NRF funded project will work directly for a Community Interest Company (CIC), 'Gateway Family Services', which has recently been established. The CIC was registered last year as a trading not-for-profit company and essentially is a social enterprise that invests its surplus back into the community. It is supported by South Birmingham PCT and works in partnership with other PCTs in the city, the Health and Well Being Partnership, and the Strategic Health Authority.
- 3.7. Gateway Family Services currently employs 50 para-professionals, who are managed by five coordinators also employed by Gateway Family Services. Para-professionals employed by these programmes will earn a pro-rata salary of between £12,000 and £18,000 per annum.

### Development of the formal learning pathway

- 3.8. The para-professionals are trained to an accredited standard using a fit-for-purpose curriculum which focuses on the core 'people-facing' skills of public service and on the more specialist requirements of the setting in which they are to be deployed. The role is intended to be progressive, so Gateway services has built in progression opportunities through formal learning routes as a way of breaking through the glass ceiling that has presented problems in the past. A diagram of this pathway – the skills escalator – can be found below.



- 3.9. The pathway ensures that people can enter the programme at different stages and progress through the levels. The programme holds an annual awards ceremony for students to recognise their achievements through the stages. The bolt-on technical competencies can be added for specific roles and are developed in conjunction with professionals based on what skills are needed to do the job.

### **The Race for Health Peer Review Visits**

- 3.10. The South Birmingham Race for Health peer review offered the team three field visits, to reflect three aspects of the current Race for Health work programme and the development of the para-professional workforce.

#### *Heartlands Child Development Centre (CDC) – Specialist Assessment*

- 3.11. Heartlands CDC is one of five specialist assessment and therapy centres working with disabled children. It is not located in South Birmingham, but the service it offers is run through the provider arm of South Birmingham PCT. The centre works with children aged 0 – 4 (although the paediatric support continues with children up to age 19) and offers multi-disciplinary therapy services. Overall co-ordination is through the specialist children's health service, but the range of other professionals and support staff who work at the centre are line managed through partner organisations.
- 3.12. The majority of the population in the area served by Heartlands CDC are South Asian, predominantly people of Pakistani origin. There is also a significant number of people of Bengali origin and new immigrant communities, particularly Somali. This means that the centre has always had to have language support through a link worker to help with issues around communication. But as the number of children going through the centre started to increase, the Clinical Coordinator felt that the centre was struggling to provide effective family support. As a team, they felt they were letting families down by focusing solely on the needs of the child and not those of the family as a whole. The centre was tapping into support from Sure Start and the Children's Centres, but the team did not feel they were doing enough themselves.
- 3.13. When the PCT started developing the para-professional workforce, the Clinical Coordinator felt there could be a real role for a Community Family Worker at the CDC, supporting the capacity of the multi-agency CDC to more effectively address these challenges. The CDC therefore became an early adopter of the role and the three inner city CDCs have now all got a Community Family Worker. The aim of the workers is to empower the families the CDC serves, largely by enabling and supporting

expectation and use of services (those of the CDC and of other public sector bodies). The Community Family Worker role therefore includes a wide range of activities, including:

- communications and supporting communication;
- assistance with resolving complex housing and benefit issues;
- signposting to other services;
- helping people to access and to use services;
- developing the capacity for family care;
- problem solving for families and professionals;
- supporting families beyond the needs represented by the clinical diagnosis of their child;
- working with the prospect and the fact of bereavement; and
- supporting inclusion and sustainable access and utilisation of services.

- 3.14. Members of the review team visited Heartlands CDC and were given the opportunity to speak to the Clinical Coordinator and Community Family Worker. Details of their findings and the recommendations they made for improving the service in future can be found in the final two sections of this paper.

#### *Riverbrook Surgery – Supporting GP Delivery*

- 3.15. Riverbrook Surgery is a progressive Primary Care centre located in the Selly Oak ward in Birmingham. The population is predominantly White, but this includes large numbers of second and third generation people of Irish descent and does not reflect the growing population of residents with South Asian backgrounds.
- 3.16. The practice has expressed concerns that there is an under-utilisation of services by people of Irish descent, a population in which coronary heart disease remains a major risk factor across generations. In addition to this, known changes in the South Asian population and known disease profiles for that population, are not reflected in the activity of the practice. These groups are known to be at higher risk and figure significantly in cases of premature mortality. The lack of case identification in the most high-risk communities is one of the most fundamental problems faced by Primary Care in tackling male life expectancy. The normative assumption is that the vast majority of non-presenting people are well or have moderate health, but are not of severe risk. This assumption is questionable for many BME groups.
- 3.17. Following from the lead role taken by South Birmingham PCT in the development of a para-professional workforce and the subsequent partnership with the Community Interest Company that it developed (Gateway Family Services), a partnership has been developed to target these ‘non-consumers’ of the

mainstream Primary Care services. The targeting is concerned with three main approaches to the problem:

- targeting people within communities by taking the support service into those communities either in group settings – social, religious, cultural – or using the concerns of the wider community to target individuals;
- offering a range of support services and basic diagnostics to raise awareness of risk, as well as to identify specific problems; and
- making it easier for people to use mainstream health and other services, helping them to do so where this presents difficulties, and developing the capacity of families and the wider community to support and sustain better links with mainstream services.

- 3.18. The pilot has received NRF funding until March 2008 and two Healthy Heart Workers will be attached to the surgery from April 2007 to deliver the following objectives:
- to show an improvement in access and utilisation of Primary Care services;
  - to show the development of care plans for higher numbers of people from high risk groups; and
  - to demonstrate appropriate levels of support which will result in sustainable reduction of high risk behaviours.
- 3.19. The pilot will begin by targeting 100 male registered patients who have been identified by the surgery as high risk and currently under-use the services provided by the practice. It will then extend its reach to those who are living in the area but are not registered with a GP, in order to raise awareness of the services available and the types of health issues they face. To do this, the surgery intends to look at how it can increase access and utilisation through changes to the service – for example, it is considering widening the usual 9-5 service by opening at the weekends and in the evenings, and carrying out home visits. They also intend to carry out a number of assertive outreach methods in a range of community settings, including local housing associations, nurseries, health sites, community and sports clubs, supermarkets, and independent pharmacies, and will have the use of a 'health bus'. The aim of these activities will be to take health promotion out to the community and raise awareness of the risks and importance of screening.
- 3.20. The added benefit of the Healthy Heart Workers is that they will be able to spend longer with people than the GPs would and it is anticipated that they will be able to work with whole families as apposed to individuals, increasing the number of people the project will reach.
- 3.21. Members of the review team visited the Riverbrook Surgery and were given the opportunity to speak to the GP, Practice Manager

and Practice Nurse leads, as well as members of the Healthy Heart Team. Details of their findings and the recommendations they made for improving the service in future can be found in the final two sections of this paper.

### *Muath Centre – Improving Men’s Health*

- 3.22. Improving male life expectancy is a major challenge for the city, as more than half the male population live in areas where life expectancy rates are well below the national average. Analysis of cause of death in men has showed that the focus should be on two areas of activity – reducing smoking prevalence particularly in the most deprived areas, and improving the prevention of coronary heart disease in Primary Care and within communities.
- 3.23. Data shows that people from lower socio-economic groups are more likely to smoke than those from higher socio-economic groups. There are also four other major influences on smoking – gender, age, religion, and tradition. In addition, the lack of case identification of coronary heart disease in the most high-risk communities is one of the most fundamental aspects of the problem faced in tackling male life expectancy.
- 3.24. Birmingham has previously lacked targeted community orientated prevention programmes, so Gateway Family Services has been developing a programme that focuses on men over the age of 40 from communities where these risks are high (including Bangladeshi, Pakistani, African-Caribbean and Irish men within the 12 target wards<sup>2</sup>). The programme has been commissioned through NRF as part of the Floor Target Action Plan, published in April 2006. A number of new areas of work were commissioned, but the largest single programme is the targeted use of a para-professional workforce to deliver community focused support to improve health behaviours and to better connect high needs individuals and groups to mainstream Primary Care services.
- 3.25. The Gateway will aim to ensure that those developing or who are most likely to develop symptomatic disease present in Primary Care; are supported to effectively use mainstream services; and are recognised as being high risk. The service will also be working with communities who are at high risk to make preventative lifestyle changes.
- 3.26. The service employs 12 full-time equivalent Healthy Heart Workers and two Coordinators. Each Healthy Heart Worker is assigned to a ward and one of their first tasks is to map out health services within the area. Thereafter, the Healthy Heart Worker role will include a range of activities, including:
  - motivating and supporting preventative lifestyle change;
  - raising awareness of screening;

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<sup>2</sup> The programme is targeted at 12 wards across the city where outcomes are worst. They are Aston, Bordesley Green, Kings Norton, Kingstanding, Ladywood, Lozells and East Handsworth, Nechells, Shard End, Soho, Sparkbrook, Stockland Green, and Washwood Heath. Only one is in South Birmingham – Kings Norton.

- facilitating men to attend screening and lifestyle checks;
  - setting goals for improved health;
  - signposting to specialist services;
  - providing opportunistic advice and promotion of Heart Health (e.g. sporting and social events);
  - operating group and one-to-one sessions for physical exercise; and
  - working with and through Primary Care to better connect people to mainstream services.
- 3.27. The programme will also work through family and peer group interventions to generate additional capacity to support and sustain behaviour change. The Healthy Heart Workers Team is currently undergoing training and will be starting work from 1<sup>st</sup> April. The funding is for a period of one year, after which an evaluation of the service is planned by an outside agency.
- 3.28. Members of the review team visited the Muath Centre and were given the opportunity to speak to the Healthy Heart Worker Team. Details of their findings and the recommendations they made for improving the service in future can be found in the final two sections of this paper.

## 4. Key Findings

### The work overall

- 4.1. The peer review team was very impressed with the **clarity of intent and level of commitment** exhibited by South Birmingham PCT in relation to its work around Race for Health and the development of the para-professional workforce. The team felt that real progress had been made over the last year, in spite of a major reorganisation (including a new Board and Management Team), and that the PCT is effectively developing a workforce that is extremely keen to improve outcomes in the community.
- 4.2. This change, the team felt, had been brought about by **a more sophisticated view of demography and a renewed enthusiasm to pilot new and innovative ways of working**. With more evidence at its feet, the PCT appears to be encouraging new models of delivery, while at the same time being honest about its limitations and the difficulties it is facing. This is a commendable and promising approach to improving services.
- 4.3. The peer review visits provided some good examples of the impact para-professionals can have within a range of settings (more details on the individual strands can be found below), but an overriding concern from all three visits was how the PCT plans to **evidence the impact and the longer term outcomes**. This is particularly important when piloting new models of service delivery – the PCT must be able to show what demonstrable effect the projects are having on services and the local community. This is not only to satisfy funding requirements or to develop bids for future funding, but for the PCT **to understand what works and what doesn't work, and how the projects should be developed in future to achieve even better outcomes**.
- 4.4. This is extremely important for the future delivery of the projects – the peer review team was fortunate enough to visit some exceptional people and settings who have taken on the para-professional role. However, **the PCT needs to be able to understand what makes those specific projects so successful if it is going to replicate them or roll them out in future**.
- 4.5. The peer review team was unclear how much local communities had been involved in the development of the new models of delivery – this is not to say that the services were not service user-led but that the team did not see any evidence of it on the day. It was therefore agreed between the team that **members of the local communities and users of the service should be an essential element of any evaluative activities of the projects in future**, so that the PCT can further understand the needs of those communities and their experiences of the new service.
- 4.6. In order to bring a strategic focus to the work under the Race for Health umbrella, the peer review team felt that it needed to **link**

**more closely with the wider race equality agenda** within the PCT. As such, the team was pleased to hear that the PCT has recently reviewed its Race Equality Scheme and has been working on developing accountability and ownership of the Race Equality Action Plan. It will now be important to make sure the Race for Health work is seen as integral part of that agenda.

### **Heartlands Child Development Centre (CDC) – Specialist Assessment**

- 4.7. The Community Family Worker who has been supporting the team at the Heartlands CDC for the past year has clearly been **making a very positive impact on the families** accessing the services at the centre. With a shift in focus from the child to the family as a whole, the addition of the Community Family Worker has meant that the families receive a much better experience when they go to the centre. The worker has been able to signpost them to other relevant services, make them more aware of their entitlements and provide advice and support where it is needed.

*'[The Community Family Worker] has made a real difference. The role is one of empowerment – it is about supporting families to help themselves. Now we have a worker who has time to support the families, not just the children.'*

(Clinical Coordinator, Heartlands CDC)

- 4.8. Moreover, the role has had **a positive impact on the Community Family Worker herself and the local community in which she lives**. The current Community Family Worker is qualified to degree level but had previously found it difficult to find employment – the role of the Community Family Worker has provided her with an opportunity to gain valuable experience and the Clinical Coordinator expects her to progress very well in her career. She was also able to secure another part time post to fit in with her role at the CDC, within the hearing impairment team in the specialist support service. At the same time, it was noted that she is sending a very positive message to the Bengali community, as a young intelligent woman who is highly valued by the CDC team.
- 4.9. The role has therefore **helped to strengthen the relationship and trust between the service and the local community**. Now that the Community Family Worker has the time to build a rapport with the families accessing the service, the Clinical Coordinator has seen a dramatic change in the quality of the home visits they carry out together. Furthermore, the Clinical Coordinator now feels that she has built a greater understanding of the needs of the Bengali community and can therefore help to make the service more culturally sensitive.
- 4.10. With some very clear benefits to the service, the peer review team felt that the CDC, with the help of the PCT and Gateway Family Services, now needs to be able to evidence those benefits. Links need to be made up and down the organisation to decide how this

data is collected and what needs to be done to **evidence the achievements of the Community Family Worker**. The worker already keeps a work diary and this type of qualitative data is useful in evidencing what support she has provided to families over time. It will also be crucial to gather evidence from the families she has supported to gauge what difference she has really made.

- 4.11. In future, the peer review team felt it would be important to **be aware of new emerging communities within the local area**, since the Community Family Worker had built up a very effective close relationship with members of the Bengali population, but there was a danger that other communities may be ignored. This presents issues around whether a separate Community Family Worker is needed for each different community or whether someone with a broader level of skills to work with different communities would be more appropriate. This may be something the PCT should consider in future.
- 4.12. The peer review team also felt there was an issue around the **qualification level of the para-professionals**. As outlined above, the Community Family Worker had been educated to degree level but had found it difficult to find employment within the NHS. It was suggested that the PCT and Gateway Family Services should consider what proportion of their students are graduates from BME backgrounds, and if the proportion is high, consider whether creating low level entry posts is a preferable solution over tackling the bigger issues around recruitment. The PCT and Gateway Family Services may wish to consider whether a more structural solution is needed.

### **Riverbrook Surgery – Supporting GP Delivery**

- 4.13. The peer review team thought the Healthy Heart Worker Team and the staff at the GP surgery were very **enthusiastic and committed** to making the project work. Staff at the GP surgery had, it appeared, developed good relationships with the Health Heart Workers and overall, the peer review team felt that the project seems to have **the potential to deliver** what it has set out to achieve. However, it was too early to see any real impact of the project (some of the workers had only been in post for a few days).
- 4.14. On hearing the proposals for what the project hopes to do in future, the peer review team thought that there would be some value in **involving the community groups** the projects intend to target early on in the process. This would help the team target interventions more effectively and perhaps gain a better understanding of why these groups are not accessing services in the first place. This could mean that measures undertaken to raise awareness of risks and widen access would be more focused and more appropriate to different groups.

- 4.15. The group also had similar concerns to the Heartlands group over **evidencing whether the project works**. The reasons for doing this have been clearly stated above, but the team felt it would be particularly important in this instance for obtaining future funding to sustain the project when the NRF funding comes to an end in 2008. The team also thought that any evaluation of the project should have a health economic aspect to it.
- 4.16. While the review team was impressed with the range of outreach activities the surgery intended to carry out with the Healthy Heart Workers and their clear focus on health inequalities, they were a little concerned that the project was **not necessarily targeting the South Asian community specifically**. The surgery had acknowledged that South Asians were under-represented on the practice registration lists, but did not consider it a problem as it was believed that after moving out of the inner city, they often remain registered with GP practices there and only re-register with local practices when their GPs are no longer practicing. While this may be true, there was a strong debate over whether a patient-centered generic initiative that would benefit everybody was better than a programme of activities targeted at high risk groups. The team was concerned that without the latter, some high risk groups like the South Asian community may slip through the net. The team thought that this should be an issue the PCT works out in discussion with their Thinking Partner.

### **Muath Centre – Improving Men’s Health**

- 4.17. The peer review team thought that the group of Health Heart Workers they met were extremely **enthusiastic and keen to make a difference**. They were very impressed with their personalities and presentational styles, and even though the team was relatively new, two of the workers had already started making progress, having accessed women’s groups within the mosques.
- 4.18. The team felt that **the skills mix in the group was a real asset**; with a range of different experiences and educational levels between them, it was clear that what one person didn’t know, another did. This meant that members of the group were really able to support one another within a team environment, and the peer review team was pleased to see that there was a real willingness to share information within the group.
- 4.19. The mapping work the workers will each be carrying out within their assigned wards will, the team thought, be **a very useful source of information** for the group and others looking to find out what health services are available in the area. The peer review team was told that there are plans to present the information as a directory of services and the team hope to be able to make it available on the internet so it can be used by others if the project does not continue when the funding ends, which the team thought was an excellent way of sharing the information.

- 4.20. The period of time that the workers will be funded for was one of the main concerns of the peer review team. While the training aspect of the role was highly valued by the Healthy Heart Workers, the period for training is fairly long, leaving less than 12 months for the workers to carry out all their tasks. The peer review team were concerned that this **timeframe may be too short** for the workers to make a real difference – in less than 12 months, they would need to carry out the mapping exercise, take on a caseload of up to 200 people each, build relationships with those people, organise events, and partake in the planned evaluation. The PCT and Gateway Family Services should start considering how the project could be sustained in future, past the end of the current funding period.
- 4.21. Following on from this, the team thought that the workers needed to **raise their profile** in order to maximise their potential within the timeframe. It was suggested that they should more proactively build links with local GPs and with the local Councillors, in order to raise awareness of what they are doing and what they are achieving.

## 5. Recommendations

5.1. The peer review team agreed that they would like to make the following recommendations to South Birmingham PCT:

- The development of data on demographics and health profiles within South Birmingham was impressive and clearly very useful for driving forward some of the work within the PCT; now is a good time to build on this work to **develop even more sophisticated data** to further the PCT's understanding of its population and to **use the data more systematically**.
- More work needs to be done around **evidencing the PCT's achievements**; it was very promising to see how far the PCT had progressed, but if the PCT wants to understand what changes those efforts have made and learn from its approach to piloting the new models of service delivery, it must make a commitment to gathering more substantive evidence on the ground.
- Moreover, if the PCT wants to understand and evidence what effect its work has had on its local communities, it needs to **involve and consult users of the services** in the whole process, to see how the changes have influenced their experiences. Talking to non-users within the community can also be a useful way of finding out why people don't access certain services and can help improve them in future.
- The Race for Health work at South Birmingham PCT has certainly become more focused over the past year but that focus now needs to be brought more closely in line with the overall race equalities agenda of the PCT so that a strategic focus is kept over the PCT's work to tackle race inequality. Having recently reviewed the RES and being in the process of developing ownership of the action plan, now is the time to **make race equality an integral part of the agenda**.
- The PCT and Gateway Family Services should **consider what proportion of the students training to become para-professionals are graduates from a BME background**, since there may be a danger of creating lower level posts for entry into employment rather than tackling some of the bigger issues around race inequalities in recruitment within the South Birmingham area. While the para-professional roles are useful in getting people the experience they need to progress in their career, if many BME graduates in South Birmingham say that they are experiencing difficulties accessing employment, this needs to be examined and the PCT may wish to take the issue forward to their Local Strategic Partnership.

## **Appendix 1: Peer Review Team**

**Michelle Cox**

*Equality and Diversity Manager, Liverpool PCT*

**Michele Daniels**

*Head of Refugee Doctors, Diversity and Health, Haringey TPCT*

**Ronny Flynn**

*Director of Health and Housing, Race Equality Foundation*

**Professor Helen Hally**

*National Director, Race for Health Programme*

**Carmel Kerr**

*Equality and Diversity Director, West Midlands Regional Assembly*

**Wallen Matthie**

*Thinking Partner, Manchester PCT*

**Doug Middleton**

*Associate Director of Primary Care, Wandsworth PCT*

**Stafford Scott**

*Thinking Partner, South Birmingham PCT*

**Dr Richard Williams**

*General Practitioner, Lambeth PCT*

**Mark Woodcock**

*Patient and Public Involvement Lead, Bristol PCT*

## **Shared Intelligence - Race for Health Learning Programme Advisors**

**Sue Charteris**

*Director, Shared Intelligence*

**Ganesh Sathyamoorthy**

*Principal Consultant*

**Laura Jenkins**

*Consultant*

## **Appendix 2: South Birmingham PCT Participants**

**Ashif Ayub**

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*Community Family Worker, Heartlands CDC*

**Stephanie Belgleonne CIM DIPM BA (HONS)**

*Head of Communications, South Birmingham PCT*

**Elizabeth Carroll**

*Operations Manager, Gateway Family Services CIC*

**Dr Naresh Chauhan**

*General Practitioner, Riverbrook Surgery*

**Professor David Cox**

*Chair, South Birmingham PCT*

**Cherry Dale**

*Commissioning Manager, Mental Health, South Birmingham PCT*

**Penny Duggan**

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**Vicki Fitzgerald**

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**Mandy Shanahan**

*Director of Human Resources and Organisational Development, South Birmingham PCT*

**Susan Stokes**

*Assistant Director of Public Health, South Birmingham PCT*

**Rita Symons**

*Director of Strategy and Commissioning, South Birmingham PCT*

**Joy Warmington**

*Chief Executive, Birmingham Race Action Partnership (BRAP)*

## Appendix 3: 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