

race for health



PEER REVIEW: NHS NORFOLK

15/16 OCTOBER 2009

Ensuring that the Equality and Diversity agenda is an integral part of NHS Norfolk's organisational culture

Outcome Paper

Contents

1. Introduction.....	1
2. NHS Norfolk and its Population	2
3. Overall Findings and Recommendations	5
4. Focus Areas of the Review: Findings and Recommendations.....	9
APPENDIX 1: BACKGROUND AND CONTEXT.....	17
APPENDIX 2: THE PEER REVIEWTEAM.....	26
APPENDIX 3: NHS NORFOLK PARTICIPANTS	27
APPENDIX 4: THE PEER REVIEW PROCESS	28

The Race for Health Learning Programme is delivered by Shared Intelligence



1. INTRODUCTION

The Peer Review

NHS Norfolk hosted a Race for Health (RfH) Peer Review on 15th and 16th October 2009. Peer Reviews are used within the Race for Health programme to share learning and good practice between PCTs, and support the host PCT to identify areas of improvement and subsequent actions in order to make those improvements. NHS Norfolk's Peer Review focused on ensuring that the Equality and Diversity agenda is an integral part of NHS Norfolk's organisational culture.

KEY QUESTIONS

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

1. To what extent does NHS Norfolk **commission services** appropriate to its local BME population?
2. To what extent does NHS Norfolk's SLA with Norfolk & Norwich Racial Equality Council support the organisation's **progress on Race for Health Pledges**?
3. How does NHS Norfolk **communicate information** about and **support access** to local health services (GPs, dentists, pharmacists, opticians, community and specialist healthcare) for BME communities who cannot speak English?
4. How can NHS Norfolk **improve its intelligence** on local BME communities, in order that they can better deliver on their pledge to reduce health inequalities?

The Peer Team worked in three sub-groups to explore each of these focus areas in detail before discussing and comparing the common strands.

2. NHS NORFOLK AND ITS POPULATION

Background Information

NHS Norfolk's population was an estimated 746,700 in mid-2007, an increase of 39,000 since mid-2001 (5.5 per cent increase), a little above the East of England average of 4.8 per cent. In the twelve months to mid-2007 the population of Norfolk rose by around 7,700. Compared with England, NHS Norfolk has maintained a relatively older age profile, with higher proportions of both men and women aged 50-54 and over.

The English Indices of Deprivation 2007 revealed that just over 24,000 people living in NHS Norfolk (3 per cent of the area's population) were living in the most deprived ten per cent LSOAs in England. On average people living in deprived areas, lower socio-economic groups and marginalised groups have relatively poorer health and poorer access to health care. There are also hidden pockets of deprivation scattered across some of the smaller towns and the more rural parts of Norfolk.

NHS Norfolk's ethnic composition has changed significantly since the 2001 Census which recorded a minority ethnic population of 27,400 (3.9 per cent of the total). By mid-2007 this is estimated to have more than doubled to 57,700 (7.7 per cent). Similarly, numbers in ethnic groups other than White rose from 1.5 per cent of the population in 2001 to around 4 per cent in 2007.

In the year to mid-2008, based on GP patient re-registrations, the county of Norfolk gained around 25,100 migrants from elsewhere in the UK and lost around 20,700, giving a net gain of around 4,400. Net losses were found to be the 20-24 and 25-29 year olds and net gains in all other age groups. People in the older age groups were a relatively small proportion of migrants but accounted for a disproportionately large share of the net migration gains.

To illustrate this, migrants aged 50 and over accounted for around only 23 per cent of in-migrants and 18 per cent of out-migrants, but 50 per cent of the area's net migration increase. There was generally a net loss of young people aged 16-24 but net gains in other age groups.

In terms of international migration, however, over the same period, NHS Norfolk gained around 7,750 people and lost around 2,930, giving a net gain of around 4,800. This was higher than the previous twelve months, when the net gain was 2,600. Though the main impact of the numbers was in Norwich (a net gain of

2,800), over the last three years all local authority Districts in the area have recorded net gains from international in-migration.

The area has received significant international migration from the EU, originally from Portugal and latterly from Poland, Lithuania and Latvia. There is in addition a largely unquantifiable element of international migration attributable to short-term migrants, here primarily to seek work and are highly mobile, but unlikely to be counted as part of the resident population.

The only data on those claiming asylum in the Norfolk Area is available for those who are being supported by the National Asylum Seeker Service. Norwich is a dispersal area for persons claiming asylum and are housed in the city while a decision is reached on their particular case. Figures provided by NASS indicate that at the end of December 2005 there were 125 persons claiming asylum and dispersed to the Norwich area, another 15 persons who are on subsistence support. These figures cover the persons claiming rather than dependants.

As can be seen, there are a very small number of asylum seekers in Norwich. They are from a selection of countries including the Democratic Republic of Congo, Iraq, Iran, Pakistan, Palestine, Russia, and Turkey. The majority of asylum cases involve persons with dependants with only 20 cases out of 50 involving single applicants with no dependants. This indicates there is evidence of a need for services for supporting asylum seekers that require considerable child support and consideration within the education system to ensure there is not a loss of learning for the children.

Gypsies and Traveller community numbers are increasingly difficult to calculate. The 2001 Census Ethnic Categories did not include Gypsies or Travellers, even though they are recognised as a distinct ethnic group for application of the Race Relations Act 1976. The only record kept of Travelling communities is the Count of Gypsy Caravans submitted for the Office of the Deputy Prime Minister. This is a count of caravans on all known sites on the day of the count. The data available is for the last completed count on the 19th July 2005. The limitation is that there is no means of calculating the persons who are living in any single caravan or an average of persons to a caravan to calculate the number of Gypsy and Traveller individuals.

The data does indicate the District Council areas that have the most resident travellers living in caravans and therefore can act as an indicator of a need for services. According to this data, the majority of sites in use over the entire of Norfolk are unauthorised sites. This pattern does not hold in different District Council areas. In King's Lynn and West Norfolk, that has the highest number of caravans, nearly half are on Private Authorised Sites. In South Norfolk and Great

Yarmouth the most caravans are on Unauthorised Sites. In all Other District areas the most caravans are on Authorised Sites.

Health inequalities

The health of people in Norfolk is generally better than the England average. Deprivation, child poverty, violent crime, obesity in children and smoking in pregnancy are lower than average, and there are better than average rates of breast feeding initiation, and physical activity in children.

There are health inequalities within Norfolk by location, gender, income and ethnicity. Over the past ten years early death rates for heart disease and stroke and for cancer have shown downward trends but the gap between the best and the worst areas is growing.

The key priority for Norfolk is the reduction of inequalities gaps across the county, particularly the inequality in early deaths from heart disease and stroke.

The NHS Norfolk Strategic Plan 'Bold & Ambitious' provides a clear framework for tackling and reducing health inequalities within the three focus areas:

- Lifestyle and Prevention
- Personalisation, Independence and choice
- Right Care, Right Time, Right Place

Using this framework and the information provided through the JSNA:

- The PCT wish to commission specifically to reduce inequalities in health outcomes, ensuring that the services provided by the NHS are focussed upon reducing the gap.
- The Trust also wants to ensure that they look beyond geography to communities in need, where they know that individuals have poorer health outcomes. These groups would include, for example, looked after children, migrant workers, people with learning difficulties and those in the criminal justice system.

3. OVERALL FINDINGS AND RECOMMENDATIONS

This section of the report details the overall findings of the Race for Health Peer Review Team, regarding the PCT's approach and progress, followed by key recommendations for improvements.

Key Findings

The Peer Review Team was very impressed with the **high energy and enthusiasm** of members of the PCT they met over the two days of the Review. Peers observed a pervading culture of commitment to making a difference for BME communities and a strong desire of wanting to do their best for all of Norfolk's residents.

The Peer Team commended the PCT on their **willingness to try new approaches and their openness to change, challenge, advice and support**. Peers detected no sense of complacency with the Trust; instead they perceived a readiness and a willing to take action. Peers also commended the PCT's self-awareness, in that they recognising they're not there yet but have embarked on a journey.

Peers met **many committed individuals** during the Peer Review who were felt to be **unswerving in driving forward the Race Equality agenda**. It was clear that across the organisation there was an openness and willingness to engage in the Race Equality agenda, and as such, Peers detected that the organisation wanted to make a change from its core. Peers very much appreciated the passion and commitment they sensed right across the organisation – from the Chair through to local Translators, and felt this demonstrated real 'leadership in action'.

Despite a turbulent period of change (i.e. the merger of five organisations into one, and the provider/commissioner split), Peers saw strong evidence of momentum in taking the race equality agenda forward. Peers could see that **much progress had been made** and how the PCT was moving forward.

For example, Peers recognised the **work that is being done to collect better evidence of Norfolk's local population and their health needs**. The PCT had appointed a member of staff specifically to write their JSNA; the organisation is taking steps to gather evidence based on ethnicity and health; and the Trust recognised that it was necessary to have soft evidence to supplement the hard data, and to feed this into overall analyses for robust local intelligence.

Peers were impressed by the **strong track record of the interventions** they visited during the review, and agreed that all three areas **stood out as good practice** in their area. For example, the City Reach Health Service and INTRAN

had both been running for ten years and the PCT had developed a three-year SLA with Norfolk and Norwich Racial Equalities Council - a relationship that seemed mature and well developed.

Areas for Development

The PCT demonstrated clear articulation of the health needs of some communities and Peers felt that this could be strengthened further by **broadening this vision for all BME communities** in Norfolk. This would provide the PCT with intelligence on the differences in health needs across the breadth of BME groups in the region, which would provide a baseline for the PCT to create targets and develop initiatives against.

Recommendation 1

It is recommended that the PCT work towards deepening their understanding of all Norfolk's BME communities, to include Portuguese, Gypsies and Travellers and Eastern European communities. It is recommended that the PCT work towards better consistency in all data collected on Norfolk's BME communities, such as identifying the health vulnerabilities of those communities and the interventions needed as a result of this information.

It was clear to the Peer Review Team that a lot of good work has been done and is being done in NHS Norfolk on race equality. To supplement these developments, the PCT could look into developing how they **capture evidence of how things are changing for BME communities** as a result of this good work. Peers suggested that the PCT clearly define short, medium and longer-term outcomes for its interventions, and how progress against these will be monitored. For example, defining what the PCT want to see change after its three year SLA with the REC.

Recommendation 2

It is recommended that the PCT develop systems of collecting and analysing data to demonstrate how they are making a difference for BME communities, for example, capturing patient experience and developing links with communities to source qualitative evidence around developments towards outcomes. Peers recommended that the PCT define targets and develop their monitoring systems to measure progress towards longer terms impacts for improved outcomes for BME communities, including how this intelligence will be used to commission and shape services.

Peers felt that there was an opportunity for the PCT to develop better **connectivity between existing areas of good practice**, as it was felt that at the moment the PCT was not getting full benefit of connecting up their strands of work. Peers were unclear how some practices related to each other in terms of

how they will collectively drive forward the Race Equality agenda and also how they feed into the wider perspective, e.g. the Local Strategic Partnership.

For example, Peers found that the INTRAN project did not have a budget for community engagement and was unaware of other existing resources that could potentially be tapped into.

Recommendation 3

It is recommended that the PCT actively encourages collaboration between its equality initiatives to enable them to get full benefit from linkages, such as sharing resources, best practice and local knowledge. It is suggested that the PCT explore how these initiatives are contributing to the LSP's community cohesion and wellbeing agendas and in this way can use the wider partnership to add value.

The Peer Review Team highlighted that a potential area for development is **supporting frontline staff**, in terms of ensuring that there is an understanding across the board in terms of the PCT's Race Equality agenda and the related expectations of frontline staff. Peers found that frontline staff they met understand the need for race equality, but didn't necessarily know what it entails or how to go about it.

Recommendation 4

Develop support and training for frontline staff in terms of delivering on the Race Equality agenda. This could include training and development on communication, advice and support offered to BME communities and understanding the RE agenda more generally, in terms of the PCT's objectives and outcomes for BME communities.

In the context of the commissioner/provider split, the Peer Review Team highlighted the potential for the PCT to develop the relationship between the two arms, in terms of communication particularly on cross-cutting issues to ensure that the organisation supports informed and evidenced-based commissioning. The PCT could look at how best to use the knowledge of expert providers, for example, the City Reach Health Service had examples of unmet need, and how to tackle and measure this. The PCT could look into how this type of information is best shared with commissioners.

Recommendation 5

In recognition of changing relationships between commissioner and provider arms, it is recommended that attention is given to maintaining this relationship in terms of using the evidence from the providing arm for effective and appropriate commissioning. Peers also suggested the development of roles and responsibilities for the provider and commissioner arms in terms of race equality.

Recommendation 6

It is also recommended that in light of the organisational split, that the cross cutting area of RE in commissioning is safeguarded. Peers noted that there are eight Boards, none with specific responsibility for RE. As such, Peers were keen to reinforce the importance that RE is well supported and that the Programme Board framework is strengthened to uphold this.

Sharing progress on RE with local communities was raised by Peers as an important area for development for the PCT. Peers witnessed progress and examples of good practice, and felt the PCT should look at how best to communicate this information with local BME communities.

Recommendation 7

It was recommended that the PCT really work to articulate and disseminate the health needs for BME communities and how this will spur action. As well as using this information as a stretch target for action (targeted outcomes).

4. FOCUS AREAS OF THE REVIEW: FINDINGS AND RECOMMENDATIONS

The Peer Review Team developed a number of findings and subsequent recommendations for each of the focus areas of the review, based on evidence presented to Peers over the two days.

Focus Area 1: City Reach Health Service

A sub-group of the Peer Review Team was asked to explore the extent to which NHS Norfolk commissions services appropriate to its local BME population. Although the City Reach Health Service was highlighted by the PCT as an area of good practice, it developed before the emergence of the commissioning and provider reorganisation.

The aim of City Reach Health Service is to provide primary health care services for people in Norwich who frequently find it difficult to access primary health care: those that are homeless, at risk of homelessness, asylum seekers, sex workers, travellers, those leaving prison or who are not accessing mainstream GP services for any other reason.

City Reach provides a hub and spoke model of service delivery with a wide range of daily outreach clinics at appropriate locations as well as having daily GP and nurse clinics at its central base. City Reach welcomes both self-referrals and referrals from a wide range of local and national agencies.

City Reach works in partnership with statutory and voluntary agencies formulating innovative, flexible and individual care pathways which enable patients to access appropriate care in an accessible format.

Key Findings

The Peer Team found the City Reach Health Service to be an **established, well run service** which catered well for the needs of vulnerable local groups. Peers found that the goal of the health service was not to 'capture' individuals but to act as an access point and signpost when individuals were ready to access mainstream services.

Peers found the service to deliver **committed, sensitive and energetic outreach** and felt that the staff working within the Health Centre had a good handle on unmet needs within the local community. The team was found to be

highly motivated and there was strong evidence of understanding the population in terms of who is accessing the service and a sense of wanting to do their best for the population.

Peers were very encouraged to find **evidence of positive outcomes** for local communities. There was good evidence of matrix and partnership working; there was anecdotal evidence around uptake of immunisation, and a decrease in the outbreaks of mumps. There was found to be evidence of good accessibility and early evidence to suggest improved health outcomes amongst the Gypsy and Traveller communities.

Areas for Development

Peers suggested that developing and **strengthening data gathering and analysis** would inform more effective commissioning, and really strengthen the PCT's decision-making process. Developing data systems would provide the information with which to crystallise health inequality outcomes, for example, information on which sections of the community are/are not currently accessing health services.

Recommendation 8

Develop systematic data collection, analysis and monitoring systems to measure progress against short, medium and longer term health inequalities outcomes and to inform decision-making. The Peer Team were unsure about data ownership, whether this lay with Providers, Commissioners, both or Patients, and therefore suggested that this needed clarification.

In terms of the new organisational structure, Peers felt it would be important for the PCT to **identify roles, responsibilities and expectations in both the Provider and Commissioning arm** for race equality.

Recommendation 9

The Peer team proposed as a useful development, for the PCT to work towards the universality (in terms of completion and use) of Equality Impact Assessments across Providers and Commissioner arms.

Peers thought it would be helpful for the organisation to look at **developing the stakeholder's 'voice'** and local knowledge. Peers found a lot of anecdote information and evidence, and encouraged the PCT to build on this in terms of capturing local information and turning this into intelligence.

The Peer Review team felt there was an **opportunity for the PCT to embark on real needs-based commissioning**. This would involve working with providers in a collaborative sense to conduct health needs analysis, service design and commissioning priorities, and building in awareness of vulnerabilities of race

groups and their health needs. It could also include ensuring connectivity in the commissioning process, activities and providers, for example, with regards to the health trainers who are working with Gypsies and Travellers, there was no sense that they've involved clinicians who work with Gypsies and Travellers in design and recruitment.

Recommendation 10

Ensure clarity on how cross cutting commissioning done. Racial equality cuts across all programme boards. It was therefore recommended that clarity is needed on how to address cross-cutting commissioners e.g. Racial Equality Cardiology.

Focus Area 2: Norwich and Norfolk Racial Equality Council (NNREC)

A sub-group of the Peer Review team was asked to explore the extent to which NHS Norfolk's SLA with NNREC supports its progress on the Race for Health Pledges.

In 2008 NHS Norfolk developed a Service Level Agreement with the NNREC not only to ensure that the Trust continue to meet their legal obligations under the Race Relations Amendment Act but to further develop their work with BME communities and BME staff.

The NNREC act as critical friend and provide support for the PCT's Equality and Diversity Steering Group and BME Staff Network. At the NNREC's AGM this year, NHS Norfolk received an award for progress made around the race equality duties. Some of the areas where they are supporting the PCT are to implement and monitor the Multi-Agency Protocol for reporting hate crime/incidents; developing an equality and diversity self-assessment tool for NHS Norfolk Board; audit of the Trust's equality impact assessments and support in assisting the PCT's provider arm around equality and diversity and business readiness to become a Foundation Trust.

Key Findings

The Peer Review Team found it encouraging that there was a third sector organisation working in partnership with the PCT on race equality. Peers found that NHS Norfolk can and does **benefit from the in-depth and rich knowledge** that is available to them through working with the REC. The relationship provides the PCT with linkages into public sector SLAs/LSPs which in turn present

opportunities for the Trust and a strategic overview of regional developments on race equality.

The relationship with the REC brings additional benefits in terms of the organisation having its 'finger on pulse' of local BME communities. The REC has an established local network, and has contact with some 27 local BME community groups across the region. The REC is extremely passionate about representation and therefore brings constructive challenge and support to the PCT.

Peers saw a **strong commitment from NHS Norfolk to working with the REC**. In spite of the newness of partnership (established in 2008) and past differences, the Peer team agreed that it felt like a mature relationship – one that has been well thought through and is fully operational. It is also perceived as a constantly developing relationship from both sides, which Peers commended.

The Peer Review Team was encouraged that **progress is being made as a result of the SLA**. For example, the REC assisted in the development of the BME staff network, and supported the network's involvement in shaping the PCT's Single Equalities Scheme. The REC also assisted in the redesign of the EIA template ensuring that it is as meaningful and user friendly as possible and is supporting Equality and Diversity training for the Board.

The fact that the current SLA is a **3 year commitment allows for both stability and flexibility**. There is a continual assessment of progress which allows the partnership to change direction in response to emerging intelligence. The REC and its part in the delivery of the SLA is led by both the requirements of the PCT and what they hear from communities.

Areas for Development

The Peer Team acknowledged that at the moment the SLA focuses on building relationships between the PCT and the REC and has **no real clarity on hard outcomes**. Peers felt that this could now start to develop, in terms of defining longer term, medium and short term outcomes the PCT would like to see as a result of the SLA, that link to wider health inequalities objectives and Race for Health Pledges.

Recommendation 11

Convert available data and information into outcomes and actions that are related to needs and are realistic and measurable. Outputs, outcomes and milestones all with timeframes to be developed and attached to SLA with commentary on how it will impact on Pledges (after 3 or more years). Progress against these can then monitored at 6-monthly meetings. Processes should also

be looked at that are sustainable, i.e. that eventually look at an 'exit plan' for the REC so standards and interventions are mainstreamed.

Recommendation 12

In relation to the above, the PCT and the REC should conduct an exercise to explore the equivalent Pledges and see how far they have travelled on these, as well as identify gaps and plan progression routes. This should include how tools such as the SLA with the REC can support this, which should then be explicit within the SLA and its outcome measures.

As part of the 6-monthly reviews of the SLA, Peers also felt it important that the PCT continually **recheck their relationship with the REC** to ensure it remains focused, particularly in terms of how well the SLA and its developments are permeating within the organisation.

In addition to training for Governors which the PCT and REC are developing at present, Peers felt that this **training should be widened to incorporate practitioners and providers** so that the PCT's race equality objectives and progress towards these is translated right across the organisation.

Recommendation 13

It was therefore recommended by the Peer team for the PCT to explore way of bringing providers into the SLA and its developments.

The Peer Review Team felt that there was a potential danger of the PCT relying on the REC in terms of their links into the community. As such, it was recommended by Peers that the PCT develop and **widen their routes into the community** to ensure they have communication links with all BME communities within Norfolk.

Recommendation 14

It was recommended that the Trust should push beyond the REC's networks and explore where the communication gaps are amongst the breadth of BME groups that reside in Norfolk and explore alternative pathways into these communities. For example, use of Health Trainers or Community Development Workers.

Explore the potential for **cross-boundary working and sharing intelligence**, for example, at present, the PCT and REC have plans to develop a relationship with Suffolk on their work with Gypsies and Travellers. In this way, similar avenues for working relationships and sharing good practice could be explored.

Focus Area 3: INTRAN

A sub-group of the Peer Review Team was asked to explore the extent to which NHS Norfolk communicates information about and supports access to local

health services (GPs, dentists, pharmacists, opticians, community and specialist healthcare) for BME communities who cannot speak English.

INTRAN is Norfolk's multi-agency interpretation and translation partnership that commissions the services for people who cannot speak English, whose first language is not English or who are Deaf or hard of hearing. NHS Norfolk is a major stakeholder in the partnership and most public organisations, including all health services in Norfolk are members of INTRAN and the framework is being rolled out to cover the East of England. This provides a seamless, joined-up service for Norfolk's local population, and is recognised as a model of good practice by the East of England Development Agency and the East of England Regional Assembly. Over 100 languages are spoken in Norfolk and in 2008/09 NHS Norfolk recorded 6,300 bookings for interpretation and translation in over 50 languages.

INTRAN is available through PCT staff and this covers all GP practices, dentists, pharmacies, opticians, community and specialist healthcare staff.

Key Findings

The Peer Review team felt their visit to the INTRAN service was an insightful and rewarding experience. The chance to meet the PCT's Equality and Diversity Manager, INTRAN Development Manager and one of the INTRAN interpreters was both an opportunity to scope some depth questions and hear about the benefits of the service for BME communities who wish to access health services.

The Peer team was **impressed by NHS Norfolk's championing and commitment to the interpreting and translating service INTRAN**. This was demonstrated by strong staff commitment and multi agency partnership support for the removal of language barriers for BME and disabled groups in accessing health services. The service was also appreciated as an area of good practice having been highlighted as such by the East of England development agency and regional assembly. Its significant roll out to neighbouring counties also means it is recognised as a service that 'works'.

Peers also felt that the **comprehensive and structured nature of the translation and interpreting service was a source of good practice**. The commissioning of a range of spoken, written, face to face and sign language translation and interpretation services was seen as a positive method of meeting variations of need and addressing cross cutting disability and BME access barriers.

The **robust training for interpreters was also seen as an area for appreciation**. This included strict standards on codes of conduct and the

development of locally based interpreters for face to face activity. Indeed the professional training for face to face interpreters was welcomed for its appropriateness to 'health' circumstances and capacity building within the community.

The Peer team was impressed **by the availability and clarity of printed and online literature for service users to access** the INTRAN service. This was demonstrated by the language identification leaflets and posters and the way NHS Norfolk's information for patients can be requested in different languages. Peers also felt that the **bold corporate branding** of the INTRAN logo assisted in making the service visible to health service users, partners and staff alike.

The **comprehensive level of monitoring data on interpretation and translation usage** by language, staff, and specialism was also seen by Peers as an example of a well structured service. Peers felt it demonstrated an important means of assessing whether the service is used by NHS Norfolk staff (the organisation) and BME groups as well as changes in use according to changes in Norfolk's population.

Areas for Development

Peers felt that there were a few areas of development with regards to improving the access of health services for BME communities facing language barriers. These were as follows.

While Peers felt the training provided to interpreters was of excellent benefit, they felt that the **training for PCT staff could benefit from more focussed attention**. While the staff training was said to attract good attendance from health visitors and nurses, Peers felt that this attendance could be prioritised for clinical and front line staff, as these were the points at which BME groups may face initial barriers to accessing translation and interpretation services.

Recommendation 15

Peers therefore recommend that the PCT works with the INTRAN service to internally communicate and recruit staff such as GPs, health service receptionists, GP practice managers, dentists and opticians to attend the staff training sessions. This would seek to embed the value of the service in reaching BME groups and promote its appropriate use internally.

Peers also felt that while monitoring data on the use of interpretation and translation services was important the **PCT could also benefit from the collection and analysis of data which captures evidence of health improvement** as a result of the use of interpretation and translation services. Peers felt that this type of outcome data could provide evidence of the added value of the service in improving health outcomes for the PCT. For example this

may be through an increase in the uptake of medical appointments, increased confidence to use translation services to see clinicians or an increase in the early reporting of key conditions.

Recommendation 16

Peers recommend that NHS Norfolk considers recording and analysing more outcome focused data to identify the added value of interpretation and translation services in improving health outcomes. Some examples could be the increase in uptake of GP/primary care appointments, increases in the reporting of key conditions affecting BME groups and any qualitative feedback from clinicians on the benefits of translation services for the dissemination of public health materials.

In relation to the above, Peers felt that assessing the added value of the interpreting and translation service to the PCT would reduce the risk of it being seen as an external business activity. Peers agreed that **a PCT led evaluation of the effectiveness of INTRAN would help NHS Norfolk to develop a firm understanding of the service's role in addressing race equality in health** and assist the service to demonstrate how it meets the needs of all BME communities.

Recommendation 17

It is recommended that the PCT commission or conduct an evaluation of the INTRAN service to assess its effectiveness for local communities and its contribution to addressing race equality. This should include working with local BME groups through such mechanisms as satisfaction surveys and focus groups to explore their levels of satisfaction with the service, barriers to use and areas for improvements.

Finally Peers felt that while ownership and commitment to the provision of interpreting and translating services is very visible, they also felt the PCT may benefit from **embedding INTRAN within the Patient Advice and Liaison Service and Public Patient Involvement structures**. This would seek to ensure that the services have the ability to feed through any concerns or issues of access for BME groups within the more formalised feedback structures of the PCT. It also means that issues of race equality are fed into the wider PCT rather than the sole responsibility of equality and diversity.

Recommendation 18

The Peer team therefore recommend that NHS Norfolk could begin to initiate the above process by setting up the levers to embed INTRAN within its PALS and PPI structures. This would encourage any concerns and issues raised by interpreters and translators working directly with the BME communities they serve to have a vehicle to highlight these as part of mainstream structures in the PCT.

APPENDIX 1: BACKGROUND AND CONTEXT

Introduction to our area: NHS Norfolk Demography

Population age structure

NHS Norfolk's population was an estimated 746,700 in mid-2007, an increase of 39,000 since mid-2001 (5.5 per cent increase), a little above the East of England average of 4.8 per cent. Population density in 2007 was 1.44 people per hectare, relatively low when compared with the region's 2.96 and the England figure of 3.92 people per hectare.

In the twelve months to mid-2007 the population of Norfolk rose by around 7,700 and:

- in terms of broad age groups, numbers of children increased marginally, working age adults increased by over 5% and older people (aged 65+) increased by over 2%;
- In terms of five-year age groups the most significant change was the rising number of 60-64 year olds in conjunction with the fall in 55-59 year olds, largely due to effects of the post-war baby boom.

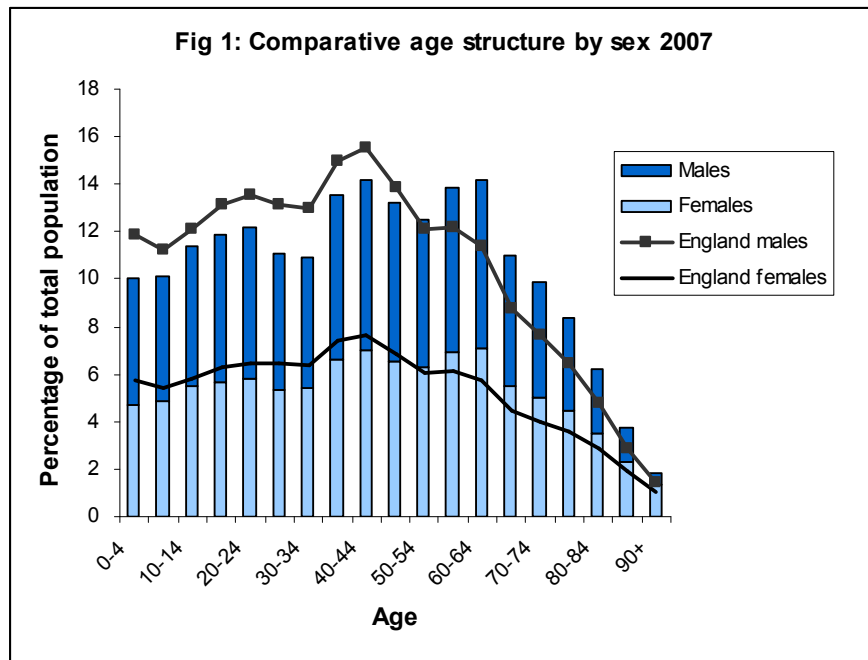


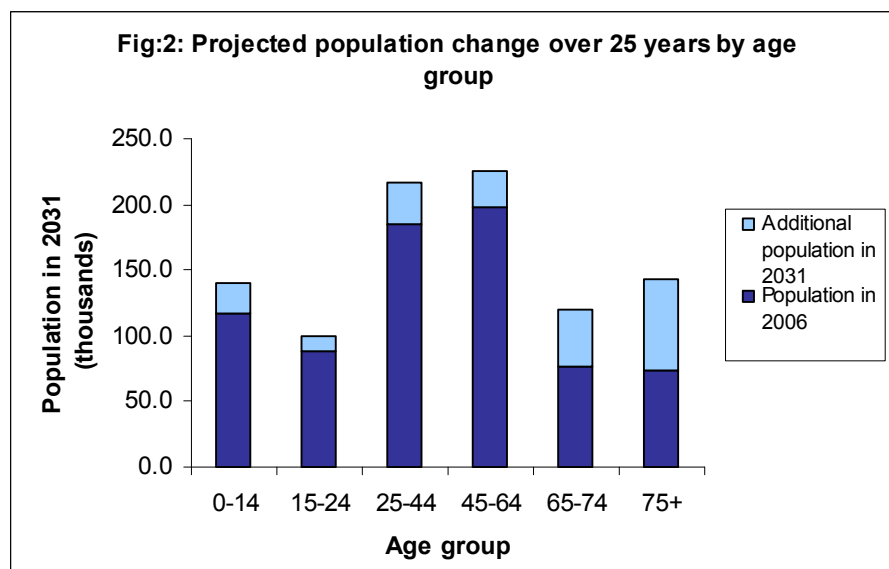
Figure 1 shows that compared with England, NHS Norfolk has maintained a relatively older age profile, with higher proportions of both men and women aged 50-54 and over and lower proportions in the 45-49 and younger age groups.

Around 21 per cent of NHS Norfolk's population in 2007 was aged 65 and over, compared to 16 per cent in England; and ten per cent of Norfolk's population was aged 75 and over compared with 7.8 per cent nationally. There are currently significantly high numbers of 60-64 and 55-59 year olds in NHS Norfolk (due to the post-war baby boom) and, to a lesser degree, in 40-44 year olds (due to high birth rates locally in the late 1960s, when national birth rates were falling).

Population projections

The ONS 2006-based population projections, which are trend-based, suggest that NHS Norfolk's population could increase from an estimated 738,800 in mid-2006 to 864,600 in 2021 and 944,800 in 2031.

Figure 2 illustrates the relative scale of change over the twenty-five years to 2031: some increase could be expected across all broad age groups, though with very little change in the young adults - people aged 15-24. The most significant numerical and proportional increase would be in those aged 75 and over, but there would also be significant increases in ages 65-74. The largest group numerically would remain those aged 45-64.

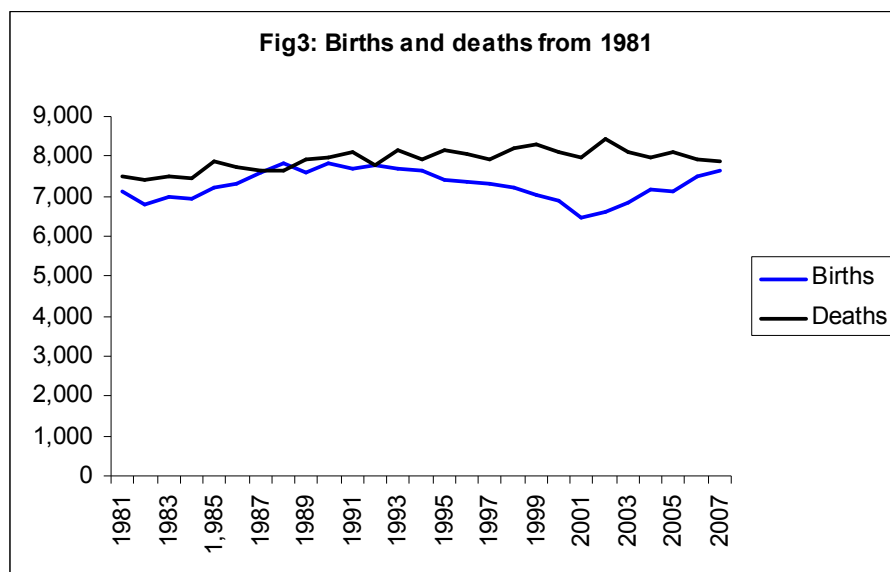


These changes would have a significant impact on local demand for health and social services as the prevalence of conditions such as dementia and disabling life events such as heart attack and stroke increase with age. For example, about one in four people aged over 85 develop dementia and this age group is

projected to increase by around 20,600 over the next 20 years (2006 to 2026). The total number of older people with dementia in Norfolk is projected to increase from 12,000 to 20,000 over the same period.

Births and deaths

In 2007 there were around 7,600 live births to mothers resident in NHS Norfolk and just under 7,900 deaths of NHS Norfolk residents, giving a net loss of 250. This excess of deaths over births has been found virtually every year since the early 1980s, the gap having widened considerably up to 2002. Since then, births have been on a strong upward trend so that the difference is now very small.



Deprivation

In December 2007 Communities and Local Government (CLG) released the English Indices of Deprivation 2007 (ID 2007). This includes county and district summary measures, and a series of separate domains and other measures at the level of Lower Super Output Area (LSOA). Just over 24,000 people living in NHS Norfolk (3 per cent of the area's population) were living in the most deprived ten per cent LSOAs in England, according to the Index of Multiple Deprivation 2007.

People who live in the most deprived areas generally have the poorest health and well being outcomes. On average people living in deprived areas, lower socio-economic groups and marginalised groups have poorer health and poorer access to health care than people resident in affluent areas and people from

higher socio-economic groups. There are also hidden pockets of deprivation scattered across some of the smaller towns and the more rural parts of Norfolk.

Ethnicity

NHS Norfolk's ethnic composition has changed significantly since the 2001 Census which recorded a minority ethnic population of 27,400 (3.9 per cent of the total). By mid-2007 this is estimated to have more than doubled to 57,700 (7.7 per cent). Similarly, numbers in ethnic groups other than White rose from 1.5 per cent of the population in 2001 to around 4 per cent in 2007.

Figure 4: Ethnicity data for NHS Norfolk, mid-2007 estimates

In thousands	All people	White*	White British	Other than White**	Minority Ethnic***
2001 Census					
Mid-2007 estimate	746.7	716.6	689.1	30.2	57.7
Percentage of population 2007	100.0	96.0	92.3	4.0	7.7
*White British, White Irish, White Other White					
**All persons other than White					
***All persons other than White British					

Migration

In the year to mid-2008, based on GP patient re-registrations, the county of Norfolk gained around 25,100 migrants from elsewhere in the UK and lost around 20,700, giving a net gain of around 4,400. Net losses were found to be the 20-24 and 25-29 year olds and net gains in all other age groups. People in the older age groups were a relatively small proportion of migrants but accounted for a disproportionately large share of the net migration gains.

To illustrate this, migrants aged 50 and over accounted for around only 23 per cent of in-migrants and 18 per cent of out-migrants, but 50 per cent of the area's net migration increase. There was generally a net loss of young people aged 16-24 but net gains in other age groups.

It isn't possible to produce these statistics for the Norfolk NHS area, because it isn't possible to eliminate internal migration between Norfolk Districts.

In terms of international migration, however, over the same period, NHS Norfolk gained around 7,750 people and lost around 2,930, giving a net gain of around

4,800. This was higher than the previous twelve months, when the net gain was 2,600. Though the main impact of the numbers was in Norwich (a net gain of 2,800), over the last three years all local authority Districts in the area have recorded net gains from international in-migration.

The area has received significant international migration from the EU, originally from Portugal and latterly from Poland, Lithuania and Latvia. There is in addition a largely unquantifiable element of international migration attributable to short-term migrants, here primarily to seek work and are highly mobile, but unlikely to be counted as part of the resident population.

Asylum Seekers and Refugees

The only data on those claiming asylum in the Norfolk Area is available for those who are being supported by the National Asylum Seeker Service. Norwich is a dispersal area for persons claiming asylum and are housed in the city while a decision is reached on their particular case. Figures provided by NASS indicate that at the end of December 2005 there were 125 persons claiming asylum and dispersed to the Norwich area, another 15 persons who are on subsistence support. These figures cover the persons claiming rather than dependants.

As can be seen, there are a very small number of asylum seekers in Norwich. They are from a selection of countries including the Democratic Republic of Congo, Iraq, Iran, Pakistan, Palestine, Russia, and Turkey. The majority of asylum cases involve persons with dependants with only 20 cases out of 50 involving single applicants with no dependants. This indicates there is evidence of a need for services for supporting asylum seekers that require considerable child support and consideration within the education system to ensure there is not a loss of learning for the children.

Source: Home Office, National Asylum Seeker Service ©

Gypsies and Travellers

Gypsies and Traveller community numbers are increasingly difficult to calculate. The 2001 Census Ethnic Categories did not include Gypsies or Travellers, even though they are recognised as a distinct ethnic group for application of the Race Relations Act 1976. The only record kept of Travelling communities is the Count of Gypsy Caravans submitted for the Office of the Deputy Prime Minister. This is a count of caravans on all known sites on the day of the count. The data available is for the last completed count on the 19th July 2005. The limitation is that there is no means of calculating the persons who are living in any single

caravan or an average of persons to a caravan to calculate the number of Gypsy and Traveller individuals.

The data does indicate the District Council areas that have the most resident travellers living in caravans and therefore can act as an indicator of a need for services. According to this data, the majority of sites in use over the entire of Norfolk are unauthorised sites. This pattern does not hold in different District Council areas. In King's Lynn and West Norfolk, that has the highest number of caravans, nearly half are on Private Authorised Sites. In South Norfolk and Great Yarmouth the most caravans are on Unauthorised Sites. In all Other District areas the most caravans are on Authorised Sites.

Source: Office of the Deputy Prime Minister, Count of Gypsy Caravans on 19th July 2005 ©

Health inequalities

The health of people in Norfolk is generally better than the England average. Deprivation, child poverty, violent crime, obesity in children and smoking in pregnancy are lower than average, and there are better than average rates of breast feeding initiation, and physical activity in children.

There are health inequalities within Norfolk by location, gender, income and ethnicity. Over the past ten years early death rates for heart disease and stroke and for cancer have shown downward trends but the gap between the best and the worst areas is growing.

The number of people under the age of 15 who self-assess being 'not in good health', people claiming incapacity benefits for mental illness, hospital stays related to alcohol, and new cases of tuberculosis are all lower than the national average.

In Norfolk, road injuries and deaths are higher than the England average, resulting in over 540 deaths each year. Education remains a top priority. GCSE attainment in Norfolk is below the England average. Local Area Agreements and priorities for action in Norfolk can be found at www.norfolkambition.gov.uk

The key priority for Norfolk is the reduction of inequalities gaps across the county, particularly the inequality in early deaths from heart disease and stroke.

The NHS Norfolk Strategic Plan 'Bold & Ambitious' provides a clear framework for tackling and reducing health inequalities within the three focus areas:

- Lifestyle and Prevention

- Personalisation, Independence and choice
- Right Care, Right Time, Right Place

Using this framework and the information provided through the JSNA, we now understand that:

- The PCT needs to commission specifically to reduce inequalities in health outcomes, ensuring that the services provided by the NHS are focussed upon reducing the gap.
- We must also make sure that the PCT looks beyond geography to communities of need, where we know that individuals have poorer health outcomes. These groups would include, for example, looked after children, migrant workers, people with learning difficulties and those in the criminal justice system.

Health Checks

Like other PCTs throughout the country, NHS Norfolk is introducing the NHS Health Check in 2009-10. The Health Check is a national screening programme to detect individuals in the 40-74 year old age range who are at risk of developing cardiovascular disease (CVD). In the NHS Norfolk area there are approximately 319,000 people in the 40-74 age band. The PCT Strategy contains a commitment to reach 80% of the eligible population. We are therefore in the process of developing a screening programme and supporting lifestyle services that will serve in the region of 40,000 people per year.

Lifestyle Support

Alongside the health checks programme it is obviously vital to be able to offer support to those who need or wish to make changes to improve their health.

Smoking

Smoking is one of the most significant contributing factors to life expectancy, health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease. NHS Norfolk provides a smoking cessation service which aims to support every person who is motivated to make a quit attempt.

Healthy Diet

Inappropriate nutrition is also a significant factor in the early onset of a range of chronic diseases, particularly CVD, certain cancers and diabetes. One of the

basics of a balanced diet is to eat at least 5 portions a day of a variety of fruit and vegetables. Estimates suggest that less than a quarter of people living in Norfolk are eating five portions of fruit and vegetables per day (JSNA).

Joy of Food

NHS Norfolk continues to host the lottery funded Joy of Food project, which has developed a programme that helps to address the inequalities in healthy eating for disadvantaged groups.

Physical Activity

Physical activity has a beneficial effect not only on physical, but also on mental health and is another major preventative factor in relation to chronic disease. Fewer than 1 in 2 men and only around 1 in 3 women in the East of England are highly physically active, that is broadly equivalent to the recommended 30 minutes of physical activity 5 times a week. In Norfolk, men are slightly more active than the regional average and women about the same.

Alcohol misuse

Alcohol misuse is a growing problem in Norfolk, with an increasing recognition that alcohol consumption, whilst being an important contributor to social welfare and the economy on the one hand, is increasingly understood to have a range of harmful consequences. In Norfolk, although the prevalence of hazardous, harmful, binge or underage drinking is below the England average, there are variations across the County, with Norwich and Great Yarmouth having much higher rates and growing rates of alcohol consumption across the County for women. The proportion of women drinking over sensible limits (more than 21 units per week), is increasing from 12 to 17%, as is the proportion of women drinking very heavily. Male drinking has remained stable - the frequency of exceeding sensible limits in men has remained stable at 26% with an average consumption of 16 units per week.

Teenage Pregnancy

Teenage conception rates in Norfolk have risen by 9.1% between 1998 and 2007, against a drop in the England average of 10.7%. The Norfolk rate per 1000 girls aged 15-17 is slightly lower than the national average (40.4% compared to 41.7% nationally) but we have wards in every area of the county where up to 1 in every 9 young women are pregnant before 18.

Teenage pregnancy is known to be strongly associated with the most deprived communities and socially excluded young people.

A range of initiatives have been developed over recent years to tackle this issue, these include;

- 21 'Hotspot' schools have been chosen to deliver a school based advice and liaison service
- Extra training in sexual health for youth workers and Connections
- Projects working with voluntary organisations to help increase spread of Teenage Pregnancy Prevention
- A strong partnership agenda between all agencies supported by the Local Safeguarding Children Board and the Corporate Parenting Strategic Board

Despite this work, progress has been slow and a concerted effort is required across all agencies to see an improvement in the statistics for the PCT's most deprived communities.

Mental Health

National and regional strategies recognise that there is no health without mental health and mental health problems are common and often go unacknowledged. Raising awareness of mental health issues and tackling stigma are major challenges for the county.

Mental health is an area where partnership working is essential – ensuring integrated and complimentary services are available in the community, and making services flexible to the specific needs of clients. In this work, the voluntary sector has a crucial role to play as the PCT seek to understand the specific needs of its communities particularly the most marginalised and hard to reach groups.

NHS Norfolk will be carrying out a Mental Health Equity Audit in the coming year.

APPENDIX 2: THE PEER REVIEW TEAM

Alan Bramwell

Community Development Manager, NHS Suffolk

Chino Cabon

Senior Associate Coordinator, Race for Health

Cynthia Chui

Equality and Diversity Officer, NHS Westminster

Sara Franceys

Head of Adult Community Healthcare, NHS Luton Community Services

Professor Helen Hally

National Director, Race for Health

Sally Kemp

Chair, NHS Berkshire East

Dr. Hasham Khan

Equality, Diversity and Engagement Manager, NHS Wandsworth

Lynette Phillips

Thinking Partner, NHS Norfolk

Arvind Sharma

Thinking Partner, Race for Health

Race for Health Learning Programme Advisors

Peer reviews are facilitated by a team of Race for Health Learning Programme Advisors from [Shared Intelligence](#). The team is:

Jacqueline Harrison

Learning Programme Advisor / Facilitator

Julie Das

Learning Programme Advisor / Facilitator

APPENDIX 3: NHS NORFOLK PARTICIPANTS

Mark Adeney

Service Manager, Primary Care, Norfolk Community Health and Care

Julie Benson

Race Equality Officer, Norwich & Norfolk Racial Equality Council

Sheila Childerhouse

Chair

Jonathan Cook

Director of Corporate Services

Jennifer Downie

Equality and Diversity Manager

Stephen Eldred

Non-Executive Director

Abraham Eshetu

INTRAN Chair

Julie Garbutt

Chief Executive

Valerie Gidney

INTRAN Development Manager

Anne Matin

Director/General Secretary, Norwich & Norfolk Racial Equality Council

Laura McCartney-Grey

Engagement Manager

Lucy Macleod

Consultant in Public Health, Health Inequalities Lead

Clive Rennie

Associate Director of Women and Children's Services

Sam Sirdar

Chairperson, Norwich & Norfolk Racial Equality Council

Kit Tawn

Interpreter, INTRAN

Jonathan Williams

Assistant Director, Health Intelligence

Tracy Williams

Lead Nurse, City Reach Health Services

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.