

race for health



PEER REVIEW: NHS LEEDS

2-3 FEBRUARY 2010

How can NHS Leeds embed Race Equality into its commissioning processes?

Outcome Paper

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The Race for Health Learning Programme is delivered by Shared Intelligence



1. INTRODUCTION

The Peer Review

NHS Leeds hosted a Race for Health (RfH) Peer Review on 2nd and 3rd February 2010. Peer Reviews are used within the Race for Health programme to share learning and good practice between PCTs, and to support the host PCT in identifying areas of improvement and subsequent actions in order to make those improvements. NHS Leeds' Peer Review focused on embedding Race Equality into its commissioning processes.

KEY QUESTIONS

The key questions for the review were as follows:

1. To what extent have some of the PCT's current **commissioning practices taken its diverse communities into account?**
2. How well do the PCT's **commissioners understand and systematically utilise equality and diversity systems and tools** in commissioning practices?
3. What more needs to be done to ensure that **race equality is truly embedded in all commissioning practices** within the PCT?

When exploring these questions, the peer review team was asked to assist the PCT to:

- consider the financial challenges facing the health service and what impact this may have;
- challenge existing tools, systems and process and consider how these can be improved to enhance outcomes;
- consider the challenges in respect of the proposed new Equality Act and forthcoming General Election.

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. LEEDS METROPOLITAN DISTRICT

Background Information

In 2005 the population of Leeds was estimated at 723,100. However, the Office for National Statistics (ONS) has recently revised the way in which population estimates are calculated; this was largely aimed at redistributing international migration, which had previously gone to London, to the rest of the country.

There are over 60,000 students studying at the two universities in the city. These represent a significant 'transient' population, many of whom live and study in the city during term time and move away during the breaks. A significant number are overseas students.

At the time of the 2001 Census there were almost 78,000 people from BME communities living in Leeds (10.8% of the total resident population). Geographic analysis of the Census data has shown how BME communities are concentrated in particular geographic areas of the city. For example, almost one-third of the city's BME population live in just three wards: Gipton & Harehills, Chapel Allerton and Hyde Park & Woodhouse.

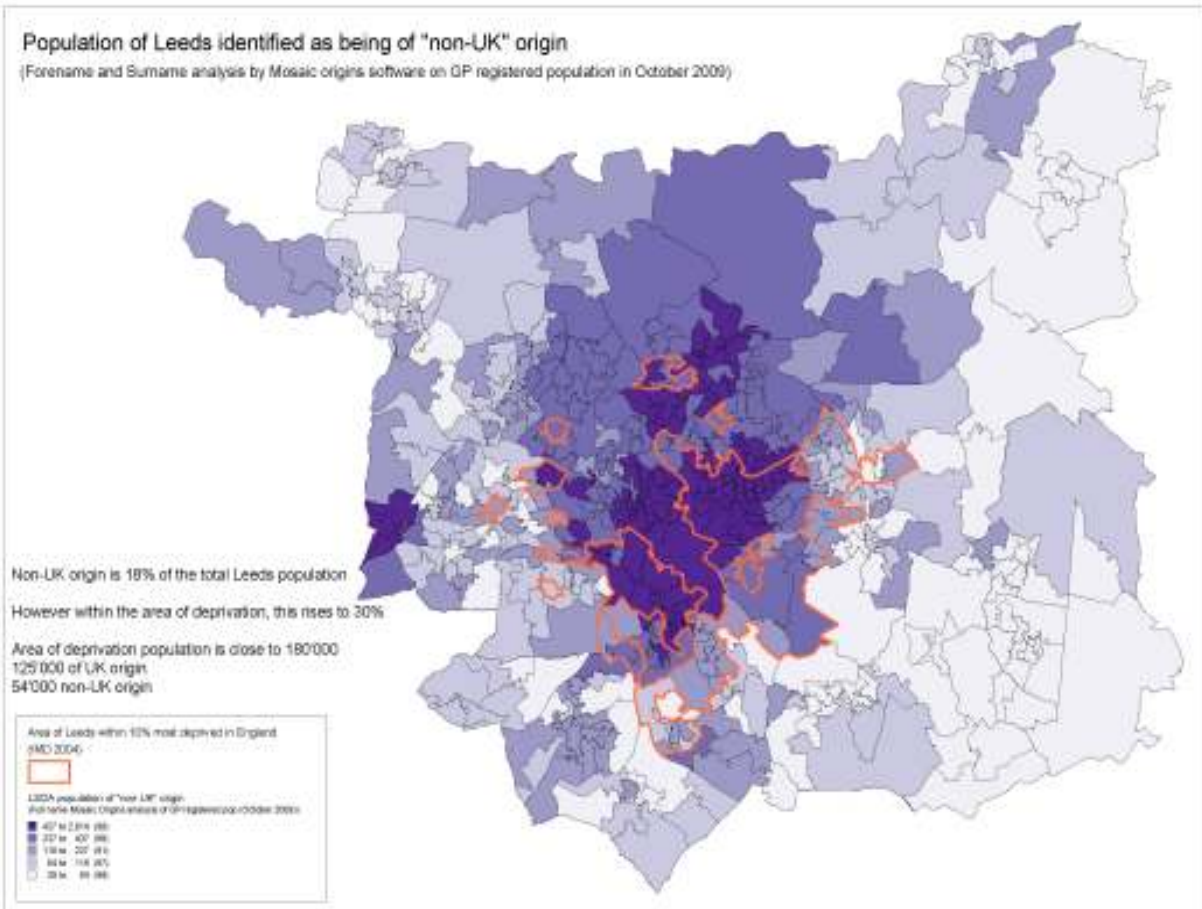
The PCT have mapped a more up to date picture of BME communities in Leeds, the distribution of BME communities have been mapped against levels of deprivation – which can be seen on the map below.

There will be significant changes in the size and profile of BME communities in the coming years. Work done by the University of Leeds' School of Geography for the Yorkshire Futures Group suggests that by 2030 the BME population in Leeds will increase by 55%. (This work was undertaken prior to the ONS revisions to the 2006 mid-year population estimates outlined above.) Leeds BME communities will also contain higher proportions of people in older age groups.

The five local authorities in West Yorkshire have jointly commissioned the University of Leeds to provide updated and more detailed BME population projections and this work will be published later in the year. Leeds is clearly a diverse place and is now home to over 130 different nationalities.

Population of Leeds identified as being of "non-UK" origin

(Forename and Surname analysis by Mosaic origins software on GP registered population in October 2009)



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 Team commended the PCT on the **level of openness** that was evident across the board. Peers found a receptive culture across the PCT and were met by a willingness to 'listen and learn' from those members of staff they met over the 2 days.

PCT staff were found to have a **strong level of commitment** to tackling inequalities along with a **good in-depth knowledge** of the local population and its needs. Peers saw a real partnership between commissioners and providers and felt that this was a real strength of the PCT.

The Peer Review Team was very impressed with the **enthusiasm and commitment of commissioners** they met throughout the review. Peers were very impressed with the work being undertaken around developing the partnership and leading the market structure. Commissioning teams were found to have a clear vision of where they are and where they wanted to get to.

At a strategic level, peers were **impressed by the Integrated Commissioning Model**. The strategic relationship between Executives and Non-Executives was found to be robust and well engaged; the discussion that peers witnessed was found to be constructive, challenging, supportive and stimulating, with a real sense of dynamism.

The peer team **liked the innovative approach within the PCT in relation to Integrated Commissioning teams and their approach** to addressing the needs of all communities in Leeds. The peers heard how the Corporate Equality and Diversity Team had merged with the Health Inequalities Team in order to work in a more efficient and co-ordinated way and maximise the impact of their work. The newly developed team will provide advice, support and expertise across all integrated commissioning teams. For example, the JSNA had identified the need for a mental health need assessment. Once completed the findings in the assessment will be used within the Mental Health and Learning Disability Integrated Commissioning Team to inform future commissioning.

The peer team commended the fact that the PCT has a **strong equality and diversity training** programme in place. Peers heard that there was a mandatory 45 minute session on equality and diversity as part of the Trust's induction package. In addition, for staff at Band 8 and above and staff with line

management responsibilities there was a mandatory full day training session covering responsibilities in respect of managing and mainstreaming equality and diversity. Any additional learning and development needs in relation to equality and diversity to support employees in achieving the relevant level within Core Dimension 6 of the Knowledge Skills Framework is identified through the Personal Development Plan and appraisal process.

Peers were happy to note that the Integrated Commissioning teams are trying to ensure that their approach to World Class Commissioning **thoroughly and explicitly incorporates equalities**.

Peers were pleased to hear about the **extensive consultation and engagement** exercise, involving nine voluntary sector organisations, which had been carried out during the development of the Fairness Scheme.

The capacity building work the PCT was embarking on to support voluntary sector organisations, as well as the commissioning of Improving Access to Psychological Therapies (IAPT), were found to be good examples of the **PCT's commitment to supporting community organisations**.

It was apparent that the PCT has a **lot of data and intelligence** and the Peer Review Team appreciated the PCT's intentions to build on this through planned work with partners (City Council and others) to integrate evidence gathering systems to inform commissioning. For example, peers heard about the joint PCT and City Council information group that is feeding updated information into the JSNA process.

Areas for Development

Peers were impressed by the large scale organisational change the PCT has been through, and it was felt that the Trust now needs to revisit, clarify and communicate their **shared vision of success** – including establishing a shared understanding of what success would look like.

Peers heard that Leeds contains areas of polarised disadvantage. There exists good practice within neighbourhoods in terms of tackling this disadvantage, such as the appointment of joint locality and health and wellbeing coordinators. The peer review team wanted to ensure that the PCT has plans in place to **support BME communities who are located outside of those identified areas of disadvantage**.

The Peer Review Team felt that a stronger emphasis and **clarity on equality outcomes** would be of benefit to the PCT in moving forward, and peers expressed a view that the PCT should be explicit and upfront about the outcomes they were working towards. Clarity on **clinical, user experience and value for**

money outcomes will be important and progress towards these can be triangulated to justify the investment in equalities going forward.

The peer team therefore recommends that the PCT capture a shared vision of success for health equalities and race equalities within Leeds, define outcomes (clinical, user experience and value for money) in terms of 'how will we know when we get there?', as well as identify how progress towards outcomes will be measured.

These outcome measures will require improving the connectivity and quality of data collection, particularly when evidencing needs. One step may be to take a 'single issue' and commission a health needs assessment for that purpose.

Peers identified an opportunity for the PCT to **prioritise key condition areas** as outlined in the Joint Strategic Needs Assessment (JSNA) with some thought to giving a weighting for tackling inequalities within this. This prioritisation would ensure the PCT was delivering on inequalities targets in addition to delivering on strategic priorities, e.g. reducing the inequality gap by 10%.

The peer team recommends that the PCT target actions on Diabetes, Coronary Heart Disease (CHD), Cancer, Infant Mortality and Respiratory Disease in taking its health inequalities work forward. These disease areas are identified priorities within NHS Leeds' JSNA and are also Race for Health Key Performance Indicators. As such, in targeting these areas the PCT would be working towards its Race Equality targets as well as its strategic priorities (as outlined in the JSNA), which would support progress towards better outcomes for patients and would represent better value for money.

Peers suggest that the PCT embark on a **targeted push on access, secondary admissions and A&E usage, focusing on** one of the condition areas highlighted above, to fully test an integrated partnership approach to include all key players, including user groups.

The peer team therefore recommends that the PCT concentrate on CHD and access, secondary admissions and A&E use in an attempt to re-direct patients to community services. This would test the integrated approach in capturing client expectations, pulling together what is known about people arriving in crisis at A&E and looking at a way forward using the Integrated Commissioning Model and linking up with Leeds City Council and Leeds Teaching Hospital Trust to do so.

Although peers found the PCT to have a lot of data and intelligence to draw on, they also felt there to be **insufficient evidence that this data and intelligence are being used to maximum effect. Peers therefore recommended that more is done** to ensure data is used to inform commissioning. This will be essential if the integrated commissioning function is to work effectively.

The peer team therefore recommends that the PCT establish a mechanism for the systematic collating, analysing and interpreting of data and for feeding this into decision-making processes.

Peers recognised that the PCT has a robust Equality Impact Assessment (EIA) process in place, and suggested that as part of the overall approach to commissioning, the PCT should push to **ensure that EIAs really are embedded** right at the beginning of the commissioning cycle. Peers also suggested that the PCT gain an understanding of how commissioned bodies can (or how they currently do) carry out such things as EIAs in order to explore how they can target services better.

The peer team therefore recommends that the PCT establish mechanisms such as staff training and development to ensure that the benefits of EIA are recognised as a gateway to good and equitable strategy development, commissioning and service planning across the board, and that the PCT work towards embedding the tool into a formalised process within the organisation.

Peers saw much evidence of community development work and were impressed with plans to systematically embed a social marketing approach. Peers felt that as a next step, it would be beneficial for the PCT to identify motivations that exist amongst local communities and understand drivers to communication and engagement, in order to inform **new strategies to influence people's behaviours**.

The peer team therefore recommends that the PCT build on its social marketing approach by exploring different routes into communities, for instance by using social networking sites. This also requires a change in focus inside the organisation so that the 'user perspective' provides insight into lived experiences. This would ensure that commissioning is a more informed process whereby communities have a role in providing a scrutiny style function to the design of services.

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 the Peers over the two days.

Focus Area 1: Commissioning Model for Coronary Heart Disease

A sub-group of the Peer Review Team visited a Phase Three cardiac rehabilitation session held at Wetherby Leisure Centre. The Phase Three session focuses on structured exercise and education and commences 4-6 weeks post event. Peers were asked to explore this particular commissioning model and assess whether the approach took into consideration Leeds' diverse communities.

The Peer group was also asked to explore referral pathways into Cardiac Rehabilitation Services, in order to find out how the PCT could increase uptake on the service from all communities in the city.

Key Findings

The Peer Team found the service was a **good evidence-based delivery model** working across primary and secondary care that provided education, support, risk factor management and structured exercise programmes. In particular, peers found that there was very good commissioning leadership and commitment for the service. Peers saw evidence of a **good working relationship** between the commissioner and the service provider.

Peers found that the Phase 3 Cardiac Rehabilitation service had a **committed and motivated** team who delivered a **flexible service to meet the needs of the individual** user. For example, the peer team witnessed an exercise session in practice and were shown how patients 'tailored' their own exercise programmes by rating perceived exertion levels through the Borg Scale after each station on the training circuit.

Peers felt there was **good geographic spread of the service** across Leeds. The service was currently being delivered in five leisure centres in different parts of the city.

Service staff **understood their clients and some of the barriers to access that they face**. For example, the peer team heard of barriers the team had identified for older Asian women in terms of their wider families' trust and confidence in the service, as their cultural belief about rehabilitation is that it consists predominantly of medical treatment.

There was found to be a **good vision for the service** in terms of continuing to expand the user base and good work is currently underway to **engage key stakeholders, staff, patients and the public in the design of the service**. For example, the Peer Review Team was told of an upcoming Market Stewardship event designed to explore with potential partners ways in which they could enhance the basic pathway.

Areas for Development

Peers suggested that developing and **strengthening data gathering and analysis** would lead to more informed and systematic service improvements and ensure that the views of users (and non-users) from different sections of the community and being fed into service improvements to ensure equitable and culturally sensitive service delivery.

The peer team therefore recommends that systems are established to regularly collect monitoring data, for example, numbers of referrals, number of patients taking up the service and number of drop-outs, equality monitoring, and patient experience data. It is also recommended that this data is routinely analysed and communicated to all stakeholders, as well as being used to inform service improvements and fed into the PCT's wider commissioning process.

As part of the monitoring process, peers felt it important that the team also monitor the ethnic make-up of its delivery staff (which may also have an impact on the uptake of certain communities) in line with the PCT's Single Equality Scheme, as well as systematic monitoring of the quality and accessibility of the service across the city.

The peer team felt that the service would benefit from clear links with the wider CHD strategy, in terms of how it is contributing to the corporate objective of reducing CHD. This clarification could then be used as a basis to develop clear outcomes and targets, which will provide evidence of how the service contributes to corporate objectives, for example in reducing health inequalities.

The peer team therefore recommends the development of a clear plan that fits in with the wider CHD strategy, which includes the identification of priority areas and targeted actions for specific groups, as well as the development of clear outcomes and targets.

The Peer Team heard that social isolation¹ had been identified by the delivery team as a barrier that patients faced in terms of accessing the Phase 3 service. At present, this issue had not yet been explored in a coordinated way with key partners. As such, peers suggested that the team begin work with the local authority on possible ways to tackle social isolation issues to enhance the pathway.

The peer team therefore recommends that, as part of the team's plans to engage key stakeholders to enhance the pathway, the local authority is brought on board to explore ways in which the issue of social isolation could be overcome in partnership.

Peers heard that, at present, referrals within the acute trust only cover one hospital site in the city and only within the cardiology wards within this site. Peers also heard that patient admissions are very short so there is a risk that not all surgical patients are seen by the rehabilitation team. Peers felt that these factors meant that **potential service users were inadvertently 'slipping through the net'** and as such, peers felt the service would benefit from more pro-active case finding.

The peer team therefore recommends engagement in pro-active case finding as at present there is too much reliance on the acute trust staff for referrals. Peers also recommended that the team look to take the service beyond the national model and encourage referrals from other sources, for example GPs (fast track to Phase 3 for patients 'at risk') and the NHS Health Check.

The Peer Team were impressed with the friendly, relaxed and supportive environment the team had created for the delivery of Phase 3 rehabilitation service within the leisure centre. Peers felt that the service would benefit from enhancing the environment further, making it more culturally sensitive and building on the motivations of different community groups. It was felt that this would help to break down any barriers that exist for certain communities.

The peer team therefore recommends that the team work to create a more culturally sensitive environment for Phase 3 rehabilitation service, for example by exploring different types of music, different types of exercise (e.g. dance and prayer movements derived from different cultures) and including the element of 'spirituality' within the service along with education and exercise, which is a very important feature of recovery for some communities.

Peers felt that it would be very beneficial to the service if the team could bring one or two local GPs on board as key stakeholders. Peers heard that a barrier

¹ Social isolation is a term used to describe withdrawal or avoidance of social contact or communication. Social isolation can affect access to public services for some communities more than others, for example, older BME groups who may be more likely to experience social isolation.

faced specifically by Asian patients was the fact that the Cardiac Rehabilitation Service was not perceived (or communicated) as a formal medical treatment. Peers agreed that if patients thought of the service to be more of a medical prescription than an offer it could help with uptake from certain communities. GPs could also be encouraged to refer 'at risk' patients to participate in Phase 3 to enhance the Cardiac prevention pathway.

The peer team therefore recommends that the team work with GPs and medical staff to encourage them to champion the service more, so that patients see the service as part of their outpatient treatment rather than an offer. For example, a verbal offer could be followed up with a formal letter prescribing engagement in the service by a medical professional.

The Peer Team commended the delivery team's understanding on some of the barriers that existed for specific communities. Peers felt that as a next step, the team could work in a more focused way to better understand the needs of different communities in order to gain a clearer picture of the breadth of barriers that currently exist.

The peer team therefore recommends that the commissioners strengthen their links with community development workers in order to explore further the health needs of different communities. This could be a much larger piece of work within the PCT, whereby a joint piece of work is commissioned with a view to inform all community-related areas (such as access and barriers for all community groups) and link them to PCT priorities. The results of this work could inform commissioners and providers across the organisation.

Peers were also informed of another barrier the team had found: that some people did not have the time available to attend cardiac rehabilitation session. Peers suggested that the delivery team looked into ways to overcome this and make the service more flexible to meet the needs of those who do not have the time to commit to Phase 3.

The peer team therefore recommends that the service team design a 'fast track' version of Phase 3 for those people who do not have the time to commit to the full service (young people and certain communities, for example, migrant workers), and look to run 'one off' workshops within different community settings to work through some of the exercises that are illustrated within the Heart Manual to ensure sustained use.

Focus Area 2: The IAPT commissioning model mental health

The peer review team welcomed the opportunity to gain insight into the Phase II Improving Access to Psychological Therapies (IAPT) service during their visit to

NHS Leeds. The service represented an example of the PCT's integrated care pathway approach for adults with common mental health problems, ensuring equity of access, experience and outcomes for BME communities.

In addition, the peer team was given an insight into the Touchstone Support Centre. Touchstone is a local voluntary sector mental health provider and is part of the successful consortium bid to provide phase II IAPT services in Leeds. The Touchstone service focuses on offering an IAPT service to people from particular BME groups – African Caribbean, Pakistani and Irish communities.

During their visit the peer review team met with Jon Beech, the manager of the Community Development Worker Service (also provided by Touchstone), Jess Parker, Business Development Manager for Touchstone, and Richard Garland, Project Manager for Touchstone IAPT. The peer team was also given the opportunity to explore how Touchstone operated the service to ensure equality of access, experience and outcomes for the BME communities served, in line with the generic service.

Key Findings

Peers welcomed **Leeds PCT's high level support to addressing health inequalities in Leeds**. This was particularly visible in the example of the development of the IAPT service, which introduces an integrated model of care to widen access to psychological therapies for particular populations. One of these was identified as the local BME (African-Caribbean, Pakistani and Irish) population and peers agreed this was **a positive step toward** addressing race equality in a health inequalities context.

The peer team also sensed **an energy and openness to change**, which translates into seeking improvements for service users. For example, the visit to the Touchstone Support Service provided evidence of a VCS provider working in partnership with strategic commissioning arrangements to provide a better mental health service for the BME community. Peers also welcomed the **honesty of the team regarding the organisational challenges that the PCT** had been through, which had (at times) presented challenges during the operational development of the integrated care model. This also **acknowledged the distance travelled** to get the IAPT service to its current stage in the new commissioned model.

The **operational level commitment and partnership working between community services and the VCS through the commissioning process** was also seen as notable by the peer team. The relationships between the three have sought to engage, develop and strengthen the VCS. Indeed the use of the competitive dialogue tendering process for IAPT services was seen as a good model of interaction between the three partners.

Peers were similarly impressed with the fact that **Leeds PCT had already been developing innovative models around integrated care in mental health** before the national IAPT programme was commissioned. Peers reflected on the **positive enthusiasm of PCT and provider staff involved in the IAPT service** as a key driver for a continued commitment to, and the need for the greater representation of, BME groups within the commissioning process.

Finally, the visit to Touchstone also revealed that some **first steps had been made towards developing the capacity of individuals within local BME communities**. This was through the use of community development workers (CDWs) to support the commissioning process and the use of trained low intensity workers (from BME groups) as champions for delivery.

Areas for Development

In terms of areas for development, the peer team felt that their reflections come at an opportune time in the development of the integrated care pathway model for mental health. The recommendations can therefore support action when the strategic level commitment to change is in place.

Peers felt that while the proportion of the BME population within Leeds was low in comparison to other urban areas, the process of evidencing the needs of specific BME groups could benefit from **more systematic approaches to data collection**. This means improving the quality of patient feedback data across the PCT in order to identify those parts of the BME population which suffer the most in terms of health inequalities. The peer team felt that the complexity of multiple deprivation (race, disability and socio-economic deprivation) is an important consideration in the future development of the integrated care model. This would allow the service to reach the 'hidden voices' within the community who are usually those most in need.

The peer team therefore recommends improving data collection systems to better evidence the needs of specific BME groups to feed into integrated care pathway models. This can be achieved by connecting and improving standard patient data mechanisms (through clinical means) with more qualitative research methods regarding patient experience (patient focus groups, ethnographic research, staff surveys and interviews etc.).

This improved quality in the data would seek to identify more marginalised BME individuals and further identify those that need more targeted support to access the IAPT service. There may also be some benefit in securing wider experience feedback of the local BME community by creating some intelligence sharing mechanisms with local authority community/social care services.

Upon reflecting on the commissioning of the IAPT service, peers also felt that while CDWs were representing the needs of BME communities within the process, **the formal role of patient engagement and involvement needed some further clarification**. Peers felt that there would be benefits in developing mechanisms which involve patients (acute users) and wider partners directly in the design of services to effectively increase usage and access. These mechanisms may be through a number of methods, e.g. patient panels, focus groups, representation of local BME VCS organisations at commissioning events or even linking the service to wider PCT patient and involvement mechanisms (PPI) to ensure that community feedback is linking back into the commissioning process.

The peer team therefore recommends building Equality Impact Assessments (EIAs) into all processes at all levels, including patient engagement to ensure patients from different BME groups are equally and appropriately engaged. This could be a formal requirement which requires commissioners and providers to systematically seek/evidence the views of communities and probe the evidence of need and representation amongst BME groups before services are commissioned. It also ensures a more proactive approach to race equality.

Mechanisms also need to be developed which involve patients and partners directly in the design of services to effectively increase access and the quality of care. These may be through a number of methods, e.g. patient panels, focus groups or the representation and input of local BME VCS organisations during the commissioning process.

Peers similarly felt that while an evaluation of the IAPT service is planned, **the PCT would benefit from greater clarity in terms of the outcomes it would like to see as a result of changing the commissioning process toward integrated care pathways**. A key issue for the IAPT service in the future will be around demonstrating its impact on, amongst others, BME groups. Peers felt that services will need to demonstrate what they are trying to achieve in three outcome areas - improved patient experience, clinical outcomes and value for money. These outcome measures could then be fed back into the PCT's objectives around efficiency and innovation in order to drive improvement and demonstrate how health inequalities are being tackled.

The peer team therefore recommends a clear approach to identifying outcomes when commissioning services for integrated care pathways. The PCT may need to initiate this process by working with its commissioning teams to identify what success of the new commissioning model would look like. These statements could then be used to develop clear connections between the commissioning process and the impacts or benefits for the end user (the patient).

The peer team also believed that, while the proactive approach Leeds PCT has taken to procuring services from the VCS sector is a positive approach, it must

also **ensure that the care pathway is at the heart of the commissioning process**. Peers felt that the procurement process should encourage VCS organisations to work in partnership with each other (consortia approach) to provide continuity in service to the end user. This would also mean that BME representation is reflected in the successful provider bid.

The peer team therefore recommends building on the competitive dialogue approach to commissioning and stipulating that a consortia approach to tendering is welcome, particularly if the needs of more marginal BME groups can be represented amongst those organisations that have the capacity to deliver. This also requires some considerable support in the development of smaller VCS organisations into PCT networks. The competitive dialogue approach also allows the PCT to learn from new relationships with the VCS and feedback from their experiences to improve the commissioning process.

Finally peers felt that while the integrated care pathway service such as IAPT works well in partnership with the VCS to address the needs of BME groups at operational level, **the PCT could also benefit from providing more strategic support to the role of commissioning in addressing health inequality and race equality**. This would allow for clarity in the commissioning of services as they could be evidenced on population need, including the targeting of a specific pool of providers, encouraging a single consortia approach to bidding and seeking significant collaboration from wider statutory partners (such as Local authority i.e. adult social care/community services).

The peer team therefore recommends greater clarity around strategic leadership for health inequality with regard to race equality, including identifying areas where the two overlap. This would in turn secure wider statutory partnerships around the common ambitions for Leeds and establish platforms to tackle disadvantage (deprivation and ethnicity) through commissioning. A strategic approach would support the development of effective partnerships across the VCS and wider statutory sector around shared priorities and outcomes.

Focus Area 3: Making it Happen

A sub-group of the Peer Review Team was asked to explore and review commissioning processes and tools and look at how practices, knowledge and experiences are shared across the organisation.

Following the separation of NHS Leeds' commissioner and provider functions in April 2009, the PCT underwent an organisational review. The PCT wanted to use the Peer Review process as an opportunity to reflect on the current governance structures, systems and processes in relation to embedding race equality. In

doing this, peers were asked to consider and challenge how the PCT's new integrated commissioning model might create the mechanisms for the Trust to understand and meet the needs of all of the diverse communities in Leeds.

The Peer Review team met with relevant NHS Leeds staff to explore their thoughts on the current culture, mechanisms, tools (such as EIAs) and how these are fed into the commissioning process. The Peer Group was asked to consider whether the PCT can maximise the effectiveness of tools and mechanisms, for example by using EIA as a tool to manage and improve performance in relation to health outcomes and reducing health inequalities.

Key Findings

The Peer Review Team was very impressed with the **structure of the integrated commissioning model**. The recently established commissioning cycle has equality and diversity built into the heart of the process and has been designed to enable integrated commissioning teams to seek evidence, support and advice from other PCT directorates and teams. Peers found the model to be **well thought out, organic and dynamic**. The Peer team commended the fact that the model ensures the appropriate engagement of different teams across the Trust, bringing evidence and expertise together to inform decision making.

Peers were impressed with how the model worked conceptually, but wanted to understand how it would work in practice. Peers therefore tested the approach by reviewing the core four aspects of the commissioning plans using the Diabetes care pathway. Colleagues concluded that the **model seemed to work well**, indeed much better than appears on paper. The Peers further concluded that the paperwork might benefit from review in order to better illustrate the model in the interests of clarity of presentation for partnership working.

Peers felt that within the integrated commissioning team, the **right people were around the table**. The team were found to be committed and had a complementary set of skills and ways of thinking that worked together as a collective well. Peers witnesses a real sense of cohesion within the team who seemed well versed at complementing each other within discussions.

In particular, peers found that the relationship between **Executives and Non-Executives struck a healthy balance**. Peers found that members were able to 'check and balance' one another, for example, the Non Executive was pushing for a heavier emphasis on user involvement, particularly on holding the organisation to account.

Peers found a willingness of PCT staff to 'listen and learn' and saw evidence of **constant reflection and self-evaluation**. The peer team complimented the PCT on its good process of market review. Peers heard of an example where the PCT

had decommissioned and restructured drug rehabilitation services on the back of an evaluation of the services. They are now being delivered by a community-based provider in partnership with the City Council.

The Peer Review Team was pleased to hear of a number of examples of partnership working. Peers heard how the Leeds Equality Network, chaired by the City Council, had been established to work with all partner organisation to create a more joined up approach to equality and diversity. The Equality Network has started work on the revision of the Leeds Strategic Plan. In addition, the PCT is currently exploring the possibility of a joint approach with Leeds City Council in relation to Equality Impact Assessments.

The Team was **impressed with the approach to equality training** for staff and how this was driven by needs identified in personal development plans. Peers heard that there was a mandatory 45 minute session on equality and diversity as part of the Trust's induction package. In addition, for staff at Band 8 and above and staff with line management responsibilities there was a mandatory full day training session covering responsibilities in respect of managing and mainstreaming equality and diversity. Any additional learning and development needs in relation to equality and diversity to support employees in achieving the relevant level within Core Dimension 6 of the Knowledge Skills Framework is identified through the PDP and appraisal process.

From what the Peer team saw and heard, it was felt that the PCT have more data and evidence than what they might think they have. It was therefore felt there was a **real opportunity to draw all of their existing information together** and use it to its full advantage.

Areas for Development

The Peer Review Team heard a number of examples of joint partnership working from the Commissioning Team and felt that this partnership could be strengthened further by capturing a shared vision for tackling health inequalities and race inequalities and setting out ambitions for success. As part of this vision, peers highlighted the importance of embedding a shared understanding of health inequality and race equality (in terms of the local picture) across the partnership.

The peer team therefore recommends that NHS Leeds, in partnership with the local authority and key partners, identifies 'what success looks like' in terms of vision, strategy and ways of measuring success, with a particular emphasis on establishing an agreed set of health inequality and race inequality outcomes and targets for the partnership. Peers emphasised the importance of having the outcomes validated by local communities.

Peers suggested that the PCT focuses on Race for Health Key Performance Indicators to work towards narrowing the inequality gap that exists within the city.

It was suggested that the partnership develop a specific focus on the disease areas of Diabetes, CHD, Cancer and Perinatal Mortality, and in this way would be tackling race inequalities (hitting Race for Health KPIs), health inequalities (tackling the ‘big killers’ within deprived neighbourhoods) and working towards its JSNA priority areas. Peers saw many benefits of the partnership using the equalities perspective to ‘narrow the gap’ – not only in aligning its systems to make for more efficient use of resources, but to achieve better health outcomes for the city’s deprived communities and dispersed BME communities.

The peer team therefore recommends that the PCT use its existing commitment to social marketing to target actions on Diabetes, CHD, Cancer and Infant Mortality that are set out in the JSNA as priority areas. Along with this, the PCT should develop explicit targets on reducing the race inequality that exists within these areas (which are also Race for Health Key Performance Indicators), and build the new focus areas (disease areas, risk factors, priorities) into operational plans.

In order to sell the benefits of the integrated commissioning model to partners, peers recommended that the PCT push forward on an urgent piece of work, which would provide the opportunity to clarify and establish existing relationships with partners, fine tune the model and demonstrate its benefits.

The peer team therefore recommends that the PCT lead the way on a joint piece of work, potentially ‘Access and Admission and A & E review’, using this as a priority to fine tune the integrated commissioning model and show the benefits of the model to partners, i.e. achieving better outcomes and making cost efficiencies through linking up partner activity (e.g. Total Place)².

Peers felt that the PCT could go further on its data collection and analysis processes. Peers very much supported the push by the PCT to integrate evidence sources – they heard how the joint information group for the PCT and City Council are looking at how they collate information in a more effective and efficient way.

The peer team therefore recommends that as intended, the PCT push on integrating data collection and analysis with its key partners. Peers emphasised the importance of making the most of the partnership, in terms of building in efficiencies such as data sharing and working towards shared goals.

Lastly, the Peer Team saw that there was more scope for user involvement in the commissioning process both through the commissioning teams and more widely. Peers heard of proposals to develop a Patient Advisory Group for NHS Leeds, which would assist in embedding a culture of patient involvement across all

² Total Place is an initiative that looks at how a ‘whole area’ approach to public services can lead to better services at less cost. It aims to identify and avoid duplication between organisations – delivering a step change in service improvement and efficiency.

integrated commissioning teams. Peers felt that there was an opportunity for the PCT to engage with local communities on some of the above recommendations, particularly around validating health equality and race equality outcomes.

The peer team therefore recommends that the PCT works with its partners to develop action plans to engage with Leeds' diverse communities in its strategic developments and commissioning processes. This could mean, for example, engaging local communities in developing key outcomes for tackling race inequalities within the priority disease areas. It was also recommended that the PCT explores the potential for patient representation within the integrated commissioning model.

APPENDIX 1: BACKGROUND AND CONTEXT

Introduction to Leeds Metropolitan District

The city of Leeds is recognised as one of Britain's most successful cities. It has transformed itself over the last 20 years from a mainly industrial city into a broad based commercial centre, the most important financial, legal and business service centre outside London.

The Leeds Metropolitan District covers 552 square miles, which includes a main city area, surrounded by small towns, villages and countryside. The population has grown by over 27,700 in the last five years.

Leeds is the largest city in the Yorkshire and Humber region and is the biggest retail and employment centre. Leeds is a quality place to live, work and raise families and has attracted the largest absolute increase in population in the country, 4.9% since 2001. The current estimated population of approximately 750, 200 embraces a rich diversity of over 130 different nationalities.

Overview of the current population

In 2005 the population of Leeds was estimated at 723,100. However, the Office for National Statistics (ONS) has recently revised the way in which population estimates are calculated; this was largely aimed at redistributing international migration, which had previously gone to London, to the rest of the country.

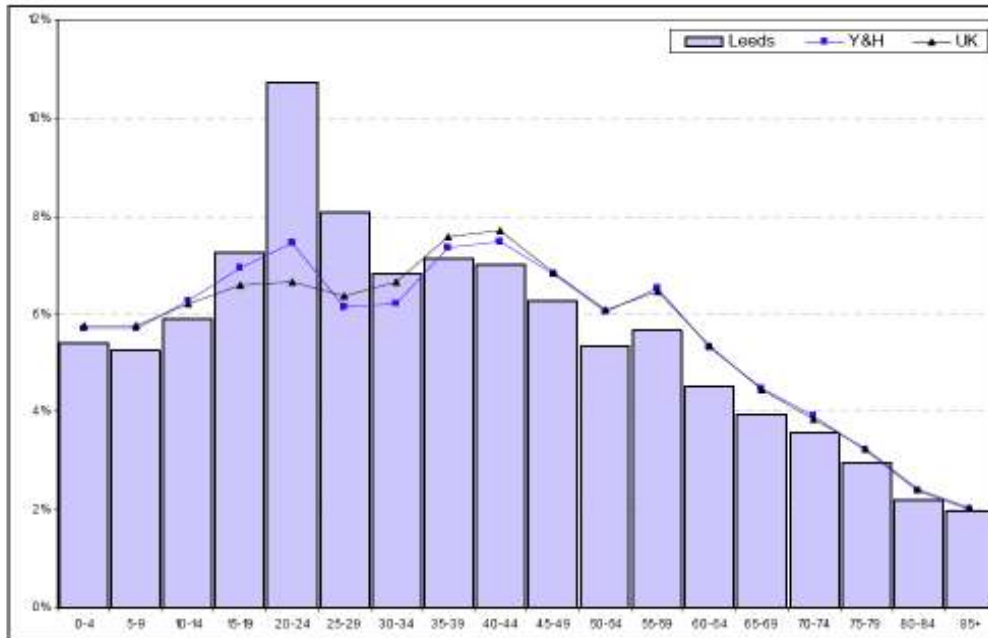
The table below provides a summary of the 2006 population structure by broad age bands and gender (numbers may not add up due to rounding).

Age Band	Male	Female	All
0 – 4	20,900	19,700	40,600
5 – 14	42,900	40,800	83,600
15 – 19	27,500	26,900	54,400
20 – 29	71,500	69,300	141,000
30 – 59	141,700	145,200	286,800
60 – 74	43,300	47,300	90,500
75+	20,200	33,200	53,400
Total	367,800	382,500	750,200

Source: ONS

There are over 60,000 students studying at the two universities in the city. These represent a significant 'transient' population, many of whom live and study in the city in term time and move away during the breaks. A significant number are overseas students.

Leeds has a significantly higher proportion of 15–29 year olds compared to both the region as a whole and the UK; the proportion of older people is slightly below the regional and national averages. While the proportion of older people does mirror national trends, this is definitely not the case for younger people.



2006 Age profile of Leeds vs Yorkshire and the Humber (Y&H) and the UK

Age band	Leeds	Y&H	Variance (Δ)	UK	Variance (Δ)
0–14	16.56%	17.69%	(1.1%)	17.72%	(1.2%)
15 –29	26.05%	20.54%	5.5%	19.60%	6.4%
30–44	20.95%	21.05%	(0.1%)	21.96%	(1.0%)
45–64	21.81%	24.68%	(2.9%)	24.73%	(2.9%)
65+	14.65%	16.04%	(1.4%)	15.99%	(1.3%)

Population development

ONS population projections indicate that the Leeds population will increase from 750,200 in 2006 to 974,300 by 2031, with figures for children and young people and for older people as shown below.

Age band	2006	2031
Children and young people		
0–4	40,600	56,200
5–9	39,500	54,500
10–14	44,100	53,300
15–19	54,400	58,200
Older people		
65–69	29,700	40,000
70–74	26,680	33,800
75–79	22,200	26,700
80–84	16,400	24,600
85+	14,800	28,500

Black and minority ethnic (BME) communities

A breakdown of the total population by ethnicity may be found in the table below.

Ethnicity	% of Population
White	
British	89.17
Irish	1.19
Other	1.49
Mixed	
White & Black Caribbean	0.64
White & Black African	0.12
White & Asian	0.36
Other	0.24
Asian or Asian British	
Indian	1.72
Pakistani	2.11
Bangladeshi	0.35
Other	0.33
Black or Black British	
Caribbean	0.94
African	0.34
Other	0.16
Chinese or other	
Chinese	0.48
Other	0.35

Source: Census 2001

At the time of the 2001 Census there were almost 78,000 people from BME communities living in Leeds (10.8% of the total resident population). Geographic

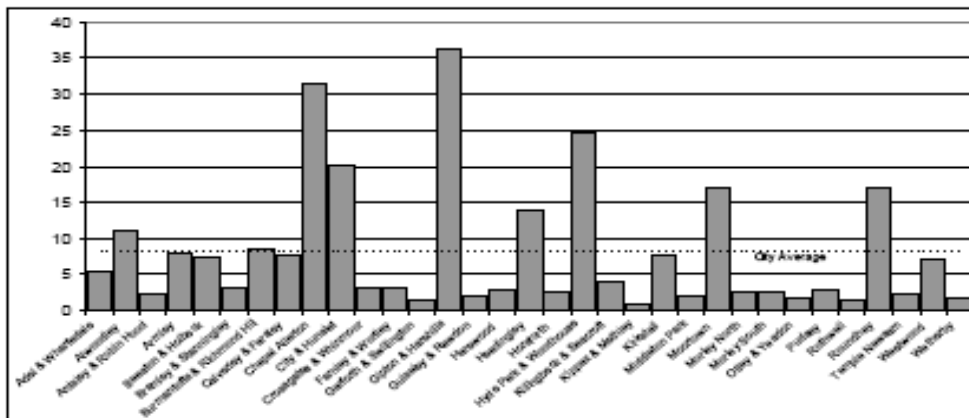
analysis of the Census data has shown how BME communities are concentrated in particular geographic areas of the city:

- Almost one-third of the city's BME population live in just three wards: Gipton & Harehills, Chapel Allerton and Hyde Park & Woodhouse.
- People from BME communities account for over 40% of the resident population in Gipton & Harehills, in Chapel Allerton 36.5% and in Hyde Park & Woodhouse 31.4%.
- With just over 15,000 people, the Pakistani community is the largest BME community in the city; over a quarter of the Pakistani population lives in Gipton & Harehills.
- The vast majority (85%) of the city's Bangladeshi community is concentrated in three wards: Gipton & Harehills, City & Hunslet and Chapel Allerton.
- Over half (55%) of the city's Black-Caribbean community live in three wards: Gipton & Harehills, Chapel Allerton and Hyde Park & Woodhouse.

We have recently purchased Mosaic software to assist us with mapping a more up to date picture of BME communities in Leeds.

The distribution of BME communities across Leeds is shown in the table on the next page.

Distribution of BME communities across Leeds



Source: 2001 Census

There will be significant changes in the size and profile of BME communities in the coming years. Work done by the University of Leeds' School of Geography for the Yorkshire Futures Group suggests that by 2030 the BME population in Leeds will increase by 55%. (This work was undertaken prior to the ONS revisions to the 2006 mid-year population estimates outlined above.) Leeds BME communities will also contain higher proportions of people in older age groups.

	White	Mixed Heritage	Asian	Black	Chinese and Other	Total
Start (2005)	649,212	11,879	37,814	13,414	10,880	723,200
End (2030)	651,196	18,493	57,237	16,806	22,157	765,888
Change	1,984	6,613	19,424	3,391	11,276	42,688
% Change	0.3	55.7	51.4	25.3	103.6	5.9

Source: University of Leeds for Yorkshire Futures, "Yorkshire & the Humber: Population projections – Age & Ethnicity", September 2006.

The five local authorities in West Yorkshire have jointly commissioned the University of Leeds to provide updated and more detailed BME population projections and this work will be published later in the year. Leeds is clearly a diverse place and is now home to over 130 different nationalities.

Gypsies and Travellers

The national Census does not provide a separate classification for this community, so work was undertaken in 2004 to establish baseline demographic data about the Gypsy and Traveller community in Leeds. The research identified 345 Gypsy and Traveller families in Leeds, totalling 1,071 people. Approximately 58% of families live in private or social housing, and there are 46 family units on the council-owned Cottingley Springs site. At the time of the research there were 42 families living on the roadside (unauthorised sites), which is where most families visiting also live (up to 100 families each year).

As the following table shows, the age profile of the gypsy and traveller community is strikingly different from the settled population.

Age band	Gypsies and Travellers – 2004		Leeds
	Number	Rate	Rate
0 – 4 years	173	16.15%	5.71%
5 – 16 years	304	28.39%	14.29%
17 – 60 years	569	53.13%	60.05%
60+	25	2.33%	19.95%
Total	1,071		

Migrant workers

Leeds is ranked eighth in the list of local authorities in England receiving A8 National Insurance (NI) registrations from the eight EU accession countries. The only non-London local authorities to receive more A8 NI registrations than Leeds are Birmingham and Manchester.

During 2006–07, 8,480 non-UK nationals from 69 countries registered for NI numbers from addresses in Leeds. Of these 2,960 were from Poland, with other A8 nationals accounting for a further 1,000 registrations. This does not include partners, children and other dependent relatives that are anecdotally known to be accompanying those registering in order to access work. The following table details the ‘Top 20’ countries accounting for over three- quarters of all NI numbers registered in Leeds.

Country	Numbers
Poland	2,960
India	610
Slovak Republic	310
Pakistan	360
Australia	150
Republic of Lithuania	280
France	190
South Africa	90
Germany	130
Peoples Republic of China	220
Italy	70
Nigeria	200
Czech Republic	170
Republic of Latvia	130
Portugal	100
Hungary	60
Spain	120
USA	70
Bangladesh	80
Republic of Ireland	80
'Top 20' total	6,380
All	8,480

Source: Dept Work and Pensions 2006–07

There is no single, all-inclusive system in place to measure the movement of people into or out of the UK. As a consequence, there is no definitive data on the number of A8 migrants living or working in a particular area.

Asylum seekers

The arrival of asylum seekers and refugees in Leeds will also impact on the make-up of communities. In April 2008 there were 2,388 asylum seekers known to be living in Leeds – 1414 section 95 and 974 Section 4 claimants (hard case support) – originating from 57 countries. The majority of asylum seekers have been housed in inner city communities. The next table provides a summary of the numbers of asylum seekers by the top 10 nationalities.

	Section 95	Section 4	All
Zimbabwe	201	127	328
Iraq	63	201	264
Iran	135	95	230
Eritrea	132	96	228
D R Congo	136	77	213
Somalia	88	37	125
China	25	77	102
Pakistan	95	5	100
Afghanistan	76	18	94
Sudan	32	44	76

Source: Leeds City Council Asylum Seekers & Refugees Team, April 2008.

The 2,388 asylum seekers known to be resident in Leeds in April 2008 speak a total of 51 different languages (as their first language). The 10 most commonly spoken languages are listed below. There are also a number of failed asylum seekers living in Leeds. It is difficult to estimate numbers as they are often not in touch with services and become 'invisible',

The Top 10 most commonly spoken languages of asylum seekers in Leeds

	Section 95	Section 4	All
English	285	101	386
Kurdish Sorani	65	190	255
French	164	67	231
Arabic	113	108	221
Tigre	117	76	193
Farsi	117	61	178
Somali	71	25	96
Amharic	33	47	80
Chinese Mandarin	30	46	76
Lingala	38	32	70

Source: Leeds City Council Asylum Seekers & Refugees Team, April 2008.

Refugees

Data on the total number of refugees in the city is less readily available but the following tables provide some indication of the numbers settling in Leeds, where they have approached the City Council as homeless following a positive decision or where they have been previously supported in Leeds as asylum seekers.

Family Structure	No of Cases		No of Individuals	
	Positive Decision	CRD*	Positive Decision	CRD*
Couple	33	0	66	0
Couple with Children	68	19	272	82
Extended Family	11	0	41	0
Siblings	2	0	5	0
Single Parent Family	109	31	300	90
Single Person	650	0	660	0
Total	872	50	1,347	172

Source: Leeds City Council Asylum Seekers & Refugees Team, April 2008.

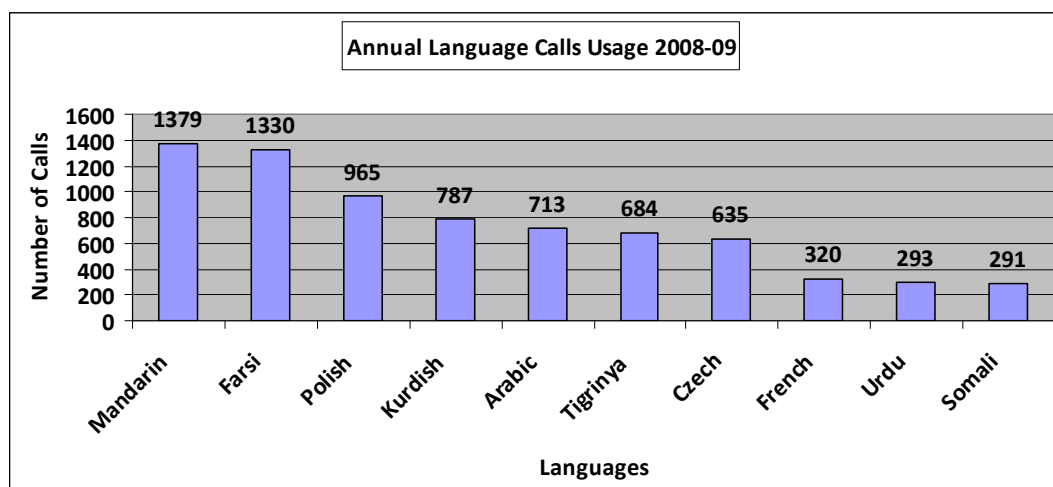
*CRD: Casework Resolution Directorate Programme

Family Structure	Number of Cases	Numbers of Individuals	Number of Children
Couple	31	62	0
Couple with Children	52	201	78
Extended Family	10	38	9
Siblings	2	5	0
Single Parent Family	98	281	145
Single Person	601	611	0
Total	794	1,197	232

Source: Leeds City Council Asylum Seekers & Refugees Team, July 2007.

Telephone Interpretation Data

The table below shows a breakdown of the top 10 languages requiring telephone interpretation during 2008 –2009 within our GP practices and community healthcare services across Leeds.



Source: Language Line

Faith communities

For the first time the 2001 Census included a question on religion. Unlike most Census questions this was a voluntary question that respondents were not obliged to answer and clearly this may influence the interpretation of the data. The following table shows the breakdown of faith communities across Leeds compared to the England averages.

Religion	Leeds Numbers	Leeds Rates	England
Buddhist	1,587	0.2%	0.3%
Christian	492,656	68.9%	71.7%
Hindu	4,183	0.6%	1.1%
Jewish	8,267	1.2%	0.5%
Muslim	21,394	3.0%	3.0%
Sikh	7,586	1.1%	0.6%
Other	1,530	0.2%	0.3%
No religion	120,139	16.8%	14.8%
Religion not stated	58,060	8.1%	7.7%

Source: 2001 Census

Geographic analysis of the Census data has again shown how faith communities are concentrated in particular geographic areas of the city:

- Almost a quarter of the city's Buddhist population is concentrated in just two wards – Hyde Park & Woodhouse and Headingley.
- Around a quarter (27%) of the city's Hindu population lives in the three electoral wards of Moortown, Headingley and Hyde Park & Woodhouse.
- Over two-thirds of the city's Jewish population lives in just two wards – Alwoodley and Moortown.
- Over half (55%) of the city's Muslim community is concentrated in four wards: Gipton & Harehills, City & Hunslet, Hyde Park & Woodhouse and Chapel Allerton.
- Over 45% of the city's Sikh community is concentrated in four wards: Moortown, Chapel Allerton, Calverley & Farsley and Roundhay.

Although Leeds as a whole is ranked as 85th most deprived (on the average of Super Output Area (SOA) scores), 95 out of the 476 SOAs in Leeds are ranked in the most deprived 10% in England on the Index of Multiple Deprivation. The majority of these are located in the inner city and just fewer than 150,000 people (20% of the resident population) live in these areas. A quarter of all children in the city live in these most deprived areas together with 18% of the city's older people.

Research has shown that people in these areas:

- live significantly shorter lives;
- are more likely to be the victims of crime ;
- have lower qualification levels; and

- live in the poorest housing and environments.

An analysis of the Index of Multiple Deprivation 2007 shows that Leeds now has:

- 22 SOAs (4.6%) in the most deprived 3% on the national scale (covering an approximate population of 33,000)
- 95 SOAs (20%) in the most deprived 10% on the national scale (covering an approximate population of 143,000)
- 131 SOAs (27.5%) in the most deprived 20% on the national scale (covering an approximate population of 197,000).

Analysis also shows that:

- The most deprived SOA in the city is ranked 113 on the national scale.(Scott Hall Road/Sholebokes).
- The least deprived SOA in Leeds is ranked 32,338 (Ainsty Road/Nidd Approach).
- Gipton & Harehills is the only ward with 100% of its SOAs ranked in the most deprived 20%.
- Eight wards have 50% or more of their SOAs ranked in the most deprived 20%.

Employment rate

Leeds has seen sustained job growth over the last 20 years and the latest figures show the overall employment rate in the city to be 75.3%, which is above the current England average of 74.3%.

Worklessness

Worklessness is a term to describe people who are either unemployed or economically inactive. **This includes:**

- people of working age who are not employed e.g. Job Seekers Allowance claimants;
- people who are neither working nor looking for a job e.g. Incapacity Benefit claimants;
- lone parents who are not working.

Worklessness presents a major challenge to the city's 'Narrowing the Gap' agenda. Its causes and effects are inter-related and manifest themselves in poverty, high crime levels, poor educational attainment, anti-social behaviour, high levels of drug and alcohol dependency, poor health, skills and labour shortages, economic stagnation, reduced levels of inward investment and low rates of business start-ups.

Working Age Client Group (WACG) data is a way of packaging together data

from the Department for Work & Pensions (DWP).

Analysis of the data is outlined below:

- almost 65,000 people of working age are not in employment and are claiming some kind of benefit. Of these – 13,754 are claiming Jobseeker’s Allowance (JSA) – 30,605 are claiming Incapacity Benefit – 9,471 are lone parents in receipt of Income Support – 3,959 are carers – 4,015 are disabled;
- there are high concentrations of worklessness in Inner East and Inner South areas;
- claimant rates in Inner West are generally above the city average but do not reflect the same concentration as is found in Inner East and Inner South;
- at 28.7%, the claimant rate in Leeds Deprived is more than double the rate for the city as a whole.

Worklessness is concentrated in the inner city areas and this is further demonstrated through the national indicator NI 153 (working age people claiming out-of-work benefits in the worst performing neighbourhoods) that classifies 53 Lower SOAs in Leeds as being in this category. The WACG claimant rate in these areas is 30.2% (more than double the city WACG rate).

Unemployment

There are two official measures of unemployment, the claimant count and the International Labour Organisation (ILO) definition. These use different methods for estimating unemployment, both of which fail to quantify its full magnitude. This section examines the different measures of unemployment and draws upon recent research by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University to quantify the ‘real level of unemployment’ and the reasons for the disparity with the official statistics.

	Claimant Count	ILO rate	Real Unemployment (CRESR)
1997	5.4	N/A	7.5
2002	2.9	4.9	5.8
2007	3.0	5.3	6.4

Source: CRESR (2007) ONS

Local authority administered benefits

Leeds Benefit Service provides a combined Housing Benefit, Council Tax Benefit and Education Benefits claim process which helps to ensure high levels of take-up of Housing Benefit, free school meal entitlement and School Clothing Allowance with little additional effort required from claimants.

The service is committed to increasing benefit take-up as a way of increasing household income levels, reducing poverty and tackling issues of financial exclusion.

- Almost 71,000 households in the city (23%) are in receipt of local authority administered benefits, almost 12,500 of which are lone parent households.
- Just over 31,500 children live in households in receipt of benefit.
- Benefit take-up levels are highest in Inner East and Inner South; in Leeds Deprived the benefit take-up rate is 44%, almost double the city average.

At the time of the 2001 Census there were just over 301,000 households in Leeds of which:

- 62.2% were owner occupied;
- 20.9% were rented from the local authority;
- 4.3% were rented from a housing association or other registered social landlord (RSL); and
- 12.6% were privately rented or some other form of rented accommodation.

Analysis of the data at Area Committee level shows:

- there are higher than average levels of owner occupation in all the outer areas;
- inner East and Inner South have the highest proportions of households renting from the local authority; and
- inner North West has the highest proportion of households in private rented accommodation.

At the time of the Census, 7.8% of households in Leeds were considered to be overcrowded (slightly above the average for England). At 19%, the Inner North West had the highest proportion of overcrowded households, due in large part to the high number of students living in 'houses in multiple occupation'.

The Census data shows that:

- almost 62,500 households (20.7% of all households in the city) did not have central heating, affecting almost 135,900 people (19.3%);
- just over 30,000 children (21%) were living in households without central heating; and
- almost 24,000 people in Leeds aged 65 and over were living in households without central heating.

The annual Leeds Fuel Poverty Survey of 20,000 houses in 2007 showed that within the private sector 30% of all households are experiencing fuel poverty, with a figure of 22% for vulnerable households.

A more detailed analysis showed that households containing the following vulnerable groups could not afford to heat their home:

- 52% of those recovering from a long-term illness;

- 44% of disabled people; and
- 32% of pensioner households.

Overall, 13% of householders stated that their health or that of their family was affected by cold conditions.

For each tenure type the proportion is:

- 24% of housing association tenants;
- 21% of private rented tenants; and
- 12% of owner-occupiers.

The latest available data shows that there are now 322,456 households in Leeds of which:

- 247,850 are privately owned (either by owner occupiers or for private renting);
- 60,063 are local authority owned 1; and
- 4,523 are owned by other Registered Social Landlords.

National projections suggest that the number of households in Leeds will increase to 393,000 by 2029.

A 'Private Sector House Conditions Survey' carried out by the City Council in 2007 estimated that there were 247,850 private sector dwellings in Leeds (either owner occupied or privately rented), of which 33% could be classified as non-decent.

It is estimated that there are 51,400 private sector dwellings in Leeds that are occupied by 'vulnerable households'. Of these an estimated 37% are classified non-decent. In order to raise the proportion of private sector dwellings occupied by vulnerable people above the 70% threshold for decency, 3,880 dwellings will need to be made decent by 2010.

There are an estimated 14,520 dwellings in Leeds that are rented through housing associations or other Registered Social Landlords. Survey data shows that 5,100 (35%) of Registered Social Landlords households are non-decent.

BME Housing Strategy

The Council has developed a specific housing strategy to address the housing needs of BME households. BME households are disproportionately likely to be homeless, living in overcrowded or non-decent housing or experiencing fuel poverty. BME households often live in housing, such as back-to-back stock, that cannot easily be brought up to the decency standard. The housing needs of BME households reflect wider socio-economic trends such as the fact that more BME households experience poverty than do white households. The housing needs of BME households may be quite specific in some cases but, in general, the

housing expectations and aspirations of BME households are the same as for white households. A key priority will be to deliver additional larger units of affordable housing that can be targeted at BME households who are living in accommodation that is overcrowded or non- decent.

Information for this section has been taken from Leeds Joint Strategic Needs Assessment and was compiled by NHS Leeds and Leeds City Council Joint Information Group

APPENDIX 2: THE PEER REVIEW TEAM

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Senior Associate Coordinator, Race for Health

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David Orekoya

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Patient and Public Involvement Manager, NHS Wandsworth

Anna Waterman

Head of Health Inequalities, NHS Westminster

Babs Williams

Commissioning Manager, NHS Bristol

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:

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Learning Programme Advisor / Lead Facilitator

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Learning Programme Advisor / Facilitator

Julie Das

Learning Programme Advisor / Facilitator

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Frank Wood

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Jane Wood

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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.