



race for health



LEICESTER CITY PCT PEER REVIEW TARGETED INTERVENTIONS

9-10 APRIL 2008

Outcome Paper

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1. INTRODUCTION

The review

- 1.1. Leicester City PCT hosted a Race for Health (RfH) Peer Review on 9th and 10th April 2008. Peer reviews are used within the RfH programme to share learning and good practice between PCTs, and support the host PCT to identify areas of improvement and actions that could be taken to address them.
- 1.2. Leicester City PCT was formed in October 2006 from the reconfiguration of Eastern Leicester PCT and Leicester City West PCT. Although Eastern Leicester PCT had participated in the RfH programme since its inception, these organisational and workforce changes created a strong sense of this being a new organisation to RfH. The review therefore came at a good time for the organisation, having spent the first 18 months of its existence developing and implementing its Turnaround Plan and now focused on building a capacity for greater investment to improve services and reducing health inequalities in the city.
- 1.3. The review therefore focused on the ways in which the PCT develops targeted primary care services for its BME communities. As such, the PCT asked the review team to consider the processes by which it engages with its local population, determines its priorities, and commissions services that specifically address the needs of BME people. In particular, the PCT wanted the review team to assess the extent to which its strategic aspirations are being translated in to the practical delivery of services.
- 1.4. Members of the Senior Management Team at the PCT were very keen that this review was not only an opportunity to demonstrate good practice, but also a learning experience for the PCT. As such, they invited the team to provide an honest and fair assessment to support them in their ambitions to tackle health inequalities within the city.

Key questions

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

1. To what extent do the PCT's **strategic aspirations** influence the **delivery of services**?
2. What impact have **targeted services** had on the health of the communities they serve?
3. To what extent has the learning from the **predecessor PCTs** been carried in to the new organisation?
4. Is the PCT making the most of its **local data and PPI activity** to address inequalities?

- 1.6. When exploring these questions, the peer review team were asked to assist the PCT specifically in:
- identifying and exploring the issues which come out of the review;
 - identifying ways in which the PCT might better link community engagement to the commissioning process;
 - exploring ways in which the PCT might maximise the use of available data; and
 - evaluating the impact of services targeted at BME communities.

The outcome paper

- 1.7. The purpose of this paper is to highlight the issues that were covered during the course of the review, and present the main findings and recommendations from the peer review team. It is therefore based on discussions and observations from the day and has been agreed by the peer review team before being sent to the PCT.

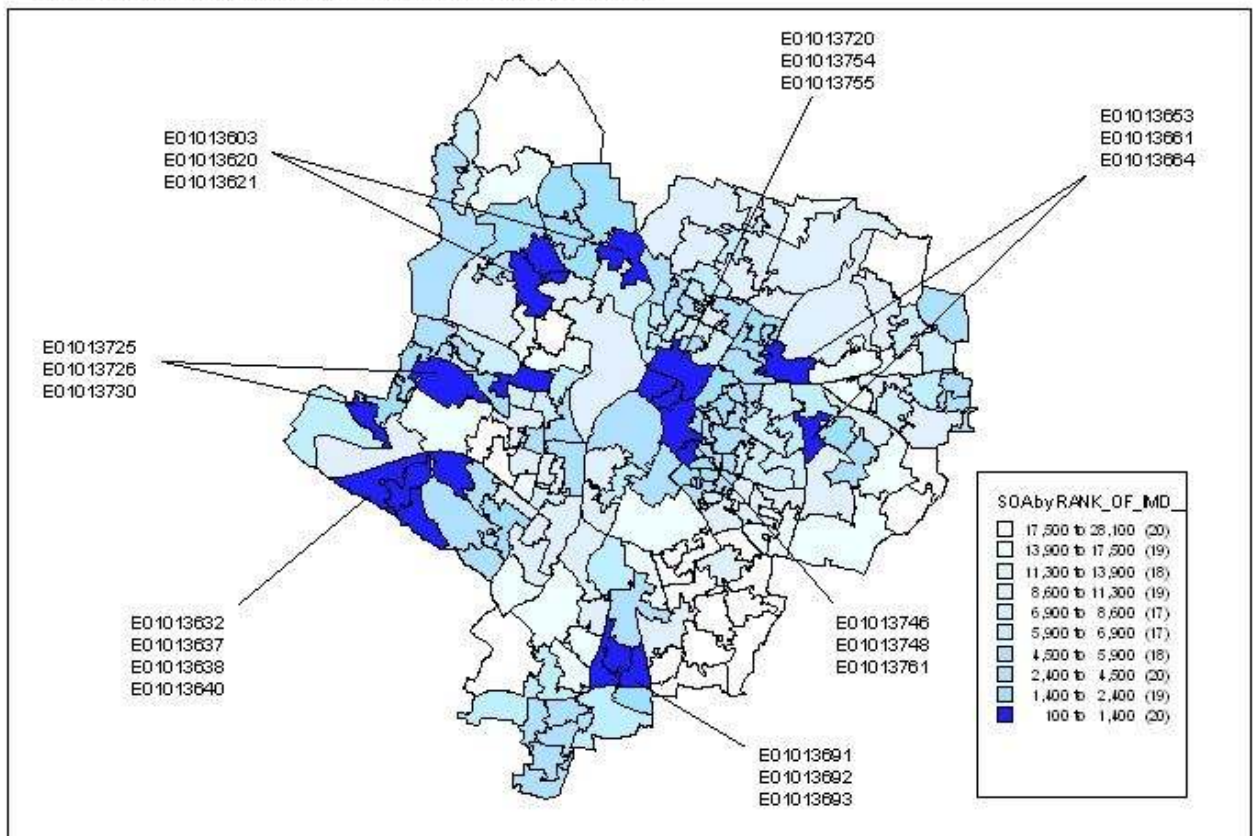
2. BACKGROUND AND CONTEXT

The City of Leicester

- 2.1. Leicester is the largest city and the largest unitary authority area in the East Midlands. It is also currently, by population, the tenth largest city in England and the thirteenth largest in the UK. Major industries in Leicester today include food processing, hosiery, knitwear, engineering, electronics, printing and plastics.
- 2.2. The city is said to be one of the most diverse in the UK and has some of the most deprived areas of the country within its boundaries. The West of the city is very different from the East, with the former home to a largely White population and the latter a far more mixed population. However, deprivation is not linked directly to ethnicity, with the most deprived areas scattered across the city, in both the East and West, and not necessarily where the highest proportions of BME communities can be found¹.

IMD 2007 Deprivation Lower Super Output Areas Across Leicester City

Dark blue Areas Indicate the Priority Lower Super Output Areas



¹ For more detailed statistical data on small areas, see www.lsr-online.org. *Leicestershire Statistics and Research Online* is sponsored by the Leicester Partnership and brings together all the major statistical data on Leicester.

Population

- 2.3. Leicester has a large and diverse population of around 280,000 people, with approximately 40% of its residents from ethnic minority backgrounds. Based upon the rate of change identified between the 1991 and 2001 censuses, by 2011 the city is predicted to become amongst the first cities in England to have a majority of people with an ethnic minority background.
- 2.4. The city boasts many Hindu mandirs, Sikh gurdwaras, and Muslim mosques, mostly converted from existing buildings. The Jain temple in Leicester is near the city centre and was the first Jain Temple to be built in the UK. The area around Belgrave Road is known as the Golden Mile, and contains many Indian restaurants, jewellery shops, and other shops catering to the large South Asian community in the neighbourhood. The annual Diwali celebrations are also held here and at the nearby Abbey Park, and are reputedly the largest Diwali celebrations outside of India. Leicester also plays host to the second largest Caribbean Carnival in the UK after Notting Hill.
- 2.5. Leicester is unique among other English cities in that its predominant ethnic minority group is of Indian background, with the majority of these communities originating from the Gujarat, or from East Africa, notably Uganda, Kenya, and Tanzania. Other smaller South Asian populations include people with Bangladeshi and Pakistani backgrounds. Approximately 75% of the South Asian community in Leicester is Hindu. A breakdown of the population by ethnicity may be found in the table below.

Ethnicity	% of Leicester Population
White	60%
British	57%
Irish	1%
European	1%
Other	1%
Asian	31%
Asian or British Asian: Indian	28%
Asian or British Asian: Pakistani	2%
Asian or British Asian: Bangladeshi	1%
Black	8%
Black or British Black: Caribbean	4%
Black or British Black: Somali	3%
Black or British Black: Other African	1%
Chinese	0.5%
Other	0.5%

Source: *The Diversity of Leicester: A Demographic Profile. Leicester City Council 2008*

- 2.6. An estimated 70-80 languages and/or dialects are spoken within the city, with Gujarati being the preferred language of 16% of residents. Continuing migration into the city has seen recent increases in the numbers of people speaking African, Middle Eastern, and East European languages. The first language of approximately 45% of Leicester's primary school children is not English.
- 2.7. Leicester has a reputation for welcoming new arrivals, and in particular has a significant Somali community, the majority of whom arrived in the years following the 2001 Census. As such, comparatively few appear in the Census statistics. Current Leicester City Council assessments suggest the Somali population is between 6,000

and 10,000 people. Many of the population have settled in family units and many are European Union nationals having received refugee status in the Netherlands, Denmark or Sweden.

- 2.8. In recent years, new groups of people have come to the city, mainly from Iraq, Afghanistan, Zimbabwe, Kosovo, Iran and other African and Middle Eastern countries. Many of these newer groups are made up of single young men. Recent estimates (2006) suggest that there were just under 1,000 people seeking asylum living in the city. An estimated 3,000-4,000 refugees also live in the city.
- 2.9. In addition to the above there are a substantial number of 'hidden migrants' living in the city including failed asylum seekers and illegal immigrants. Local estimates suggest that the number of refused asylum seekers may be as high as 2,000-3,000 people.

Community cohesion

- 2.10. As a city, Leicester has a good reputation for community cohesion. There is a high level of acceptance of the multi-ethnic, multi-cultural and multi-faith nature of the city as evident in a number of anecdotal reports as well as in several national surveys.
- 2.11. It is difficult to provide sound statistical data for the sense of community cohesion within the city. However, over the last few years a number of key questions about the values of residents and perceptions of life in Leicester have been asked in two major surveys conducted every few years. These are the Residents' Survey conducted by MORI for the City Council in 1998, 2003, and 2006, and the Best Value General Survey for the Audit Commission in 2003 and 2006.
- 2.12. In 2006, the Best Value General Survey asked the key community cohesion indicator question for the first time. This asks people if they think their local area is a place where people from different backgrounds get on well together and therefore highlights whether or not residents think they live in an area with good community relations. The results indicated that 84% of Leicester's residents agreed with this statement compared to 78% in the East Midlands region and 79% nationally. (Best Value General Survey 2006).
- 2.13. The 2005 Residents' Survey and the 2003 and 2006 General Survey asked about the 'sense of belonging' in the city. This question is based on the belief that a community is likely to be more cohesive at the local level where people feel a strong sense of belonging to their neighbourhood and/or local area. The 2005 Residents' Survey results indicated that the sense of belonging of people in Leicester to their street, local area, Leicester, England and Britain was high compared to comparable cities. A breakdown of these figures reveals that this sense was highest amongst the city's ethnic minority population. 86% of the ethnic minority population they felt they belonged to their street, area, Leicester, England and Britain compared to only 75% amongst the white population.

Health needs in Leicester

- 2.14. The challenges facing Leicester in terms of health improvement and reduction of health inequalities are significant. Indeed, **reducing health inequalities is the key**

health challenge for the city. Although recent statistics demonstrate a steady and welcome decline in all-age, all-cause mortality in Leicester, the gap with England is still wide for both men and women. Similarly the trend in the gap in mortality between Leicester as a whole and the Leicester priority areas – the most deprived areas in the city – continues to widen. The PCT sees this as unacceptable.

- 2.15. **Deprivation** is a key factor in this inequalities gap and the latest indices of Deprivation (2007) show that in comparison with the indices of Deprivation prepared in 2004, Leicester's **position has worsened** from thirty-first most deprived local authority in England to the twentieth most deprived. This is likely to be because other areas have improved and therefore moved up the scale, as opposed to Leicester itself having become more deprived.
- 2.16. These figures, however, underscore the importance of continuing to improve **the wider determinants of health**, such as education, unemployment, housing and environmental health if the PCT is to have any impact on health related behaviour and ultimately on life expectancy. The PCT has begun to unpack some of these issues by **cross-analysing ethnicity data by occupational roles/categories**. Through this process they have been able to uncover, for example, that most South Asians in the city fall into two major categories – enterprise (i.e. business owners) and industry (i.e. manual workers) – and have found that these two groups within the South Asian community have very different health needs and experiences. The industry group, for example, have much higher complications when it comes to diabetes than the enterprise group, whose hospital admissions relating to diabetes were the same as the average across the city. This process represents a more sophisticated means of understanding the differing health needs of different groups across the city and highlights the fact that deprivation often stands out more than ethnicity within the city.

Ethnicity and health inequalities

- 2.17. Health inequalities among BME communities are well documented. Given the large and diverse BME population of Leicester, the need to seriously address these issues is clearly a high priority in the work of the PCT. Below is a summary of some of the health issues facing communities in the city.
- 2.18. Leicester has a higher than average mortality rate from Coronary Heart Disease, with the rate of acute coronary events (heart attacks and severe angina) much higher among its South Asian populations, when compared to White or African Caribbean groups. South Asians develop acute heart problems at a much younger age than the population as a whole, although it is encouraging to note that in Leicester, South Asians also have higher coronary intervention rates (nearly 3/1,000, compared to 1.7/1,000 in the general population), indicating a matching level of service provision within this group.
- 2.19. The 2007 annual report from the Director of Public Health and Health Improvement has recommended that specific CVD interventions be targeted at the following population groups:
- Those in the most socio-economically deprived areas, where rates of early mortality can be twice as high as other areas of Leicester.

- Those from a South Asian background, who develop more severe forms of CVD earlier and are also likely to belong to more deprived sectors of the local population.
- Specific age groups – 40% of the life expectancy gap is due to premature deaths in people aged 50 – 69.

- 2.20. As with CVD, diabetes also disproportionately affects people of South Asian background. Currently **almost 5% of Leicester's population is registered as diabetic, with prevalence four times greater in the South Asian population**, when compared to the white population of the city. As a result, in General Practices which have a high proportion of South Asian patients, as much as 10 – 12% of the practice population has diabetes.
- 2.21. Compared to the national and regional average, premature mortality from diabetes is high in Leicester, significantly so among men. Moreover, there are a substantial number of premature deaths, mainly from heart disease and stroke, where diabetes is an important contributory factor.
- 2.22. Although the numbers of babies who die in England is at an all time low and falling, unacceptable inequalities in **infant mortality** persist. Babies from some ethnic minority families are more likely to die before their first birthday, a statistic that reflects a particular risk of poverty and socio-economic disadvantage among some ethnic minority communities, notably those from Pakistani, Bangladeshi, African Caribbean and Black African communities. In order to reduce these disparities, there is clearly a need to address barriers to accessing services for BME groups, including issues associated with language support for women accessing midwifery services. It is important to note that there is already considerable work being undertaken in Leicester to tackle the underlying determinants of infant mortality. In most areas there have been steady improvements but further work is required in all areas to deliver further reductions in infant deaths.
- 2.23. People seeking asylum, and in particular, those 'failed' asylum seekers who are destitute in Leicester constitute one of the most vulnerable groups, with the worst health outcomes. Leicester has been selected by the Home Office as a 'dispersal site' for people seeking asylum. As such, the city is home to significant numbers of asylum seekers who are either awaiting a decision on their status, or who have been refused asylum. **'Failed' asylum seekers** have no source of statutory support and frequently become destitute.
- 2.24. The healthcare needs of this group of people are significant, and are exacerbated by issues of poverty and overcrowding. Those fleeing for safety often arrive with physical disabilities caused by torture or conflict, such as amputations, bone fractures and neurological damage. HIV and TB are also particular problems in this group. Children and women are particularly vulnerable, and there are relatively high levels of mental health problems.
- 2.25. In Leicester, the male to female asylum seeker ratio is 2:1. The nationality of subjects varies over time, but in 2006 approximately 50% of asylum seekers were from the Middle East and 40% from sub-Saharan Africa. The number of asylum seekers and destitute individuals in Leicester at any one time is likely to range from 998 to 1160 individuals – of this number between 14% and 27% are destitute.

- 2.26. Another vulnerable sector of Leicester's population, with comparable health outcomes, are people from **Gypsy/Traveller communities**. Since these communities are currently not captured in ethnic monitoring procedures, the true extent of health inequalities is unknown. Anecdotally, however, men in these communities are thought to have an average life expectancy of little over 50 years of age. They also have high infant mortality, poorer dental health, higher incidences of CVD, and are less likely than the rest of the population to take up screening and preventative interventions.
- 2.27. In summary, health outcomes in Leicester are significantly influenced by the high proportion of BME residents, and high levels of socio-economic deprivation within the city. In many cases these two factors converge, with a disproportionate number of BME people living in the most deprived areas. Race equality is therefore necessarily a high priority for the PCT, and something it is keen to get right. The PCT hopes that the external expertise within the Peer Review team will provide valuable support to this aim.

Leicester City PCT

- 2.28. Leicester City PCT was formed in October 2006 from the reconfiguration of Eastern Leicester PCT and Leicester City West PCT. The area covered by the new PCT is coterminous with the boundaries of Leicester City Council. During the first 18 months of its existence, the PCT developed and implemented its Turnaround Plan, which enabled the organisation to move from a forecast overspend of £12 million to a situation where there was a small surplus. As such, the challenges faced by this new PCT were considerable, and much attention was focused on delivering a favourable financial position. Since the successful implementation of the plan, the PCT has now built a capacity for greater investment to improve services, and to reduce health inequalities in the city.
- 2.29. From the outset, the PCT sought to establish strong links with statutory partners and the local community, and continues to forge these links. The PCT has been working closely with Leicester City Council to help ensure that its patients benefit from health and social care services that are integrated and seamless. Voluntary organisations and the independent sector have become increasingly important as the PCT develops more services in response to the needs of its patients and ensures that they have a choice of the organisation, place and time of their treatment.

Equality and Human Rights in the PCT

- 2.30. Although Eastern Leicester PCT had participated in the Race for Health programme since it began, the organisational and workforce changes over the last year or so have created a strong sense of this being a new organisation to Race for Health, which is now re-establishing and strengthening its approach to Equality and Human Rights. There is a strong commitment to Equality and Human Rights at the most senior levels of the organisation, which provides a sense of direction for the agenda across the PCT. The organisation recently appointed an Equality and Human Rights Manager, and is in the process of recruiting a small equalities team to try to embed equality in to all areas of its activity.

- 2.31. As a measure of the new PCT's dedication to this agenda, a Director of Equality and Human Rights, one of the first in the country, has recently been appointed to take on a strategic role, which encompasses both the City and County PCTs, and the East Midlands Strategic Health Authority.
- 2.32. Equality and Human Rights activity within the PCT is supported by the work of an external reference group, the Equality and Human Rights Steering group, which is chaired by the Chair of the PCT, Philip Parkinson. This group provides considerable local expertise from across the various equalities strands, to scrutinise, advise and challenge the organisation on its Equality and Human Rights performance.
- 2.33. Despite this strong commitment, the PCT recognises that there are considerable challenges to meet if it is to adequately address the health needs of the city's BME communities. For example, the PCT is mindful of the need to improve ethnicity monitoring and analysis, and is working to improve outcomes for mental health and diabetes. With the recent investment in equality, the PCT is optimistic that BME communities in Leicester will see fairer, more welcoming, and improved services.

3. TARGETED INTERVENTIONS

Introduction

- 3.1. As an organisation, Leicester City PCT is committed to making a real difference to health inequalities and therefore felt it was a timely opportunity to look at the way it is developing its targeted primary care services for its BME communities.
- 3.2. When the PCT was established, it inherited many challenges and much of the focus for the first 18 months was on a financial turnaround, as highlighted above. Now that the PCT has got itself through that difficult phase, there is now a strong basis to focus on quality of services and addressing the inequalities that exist within the city. The PCT has been recognised by the West Midlands Strategic Health Authority as taking a very strong and proactive approach to identifying priorities locally.
- 3.3. Having strengthened its team – with new posts in the areas of equality and human rights; primary and community care; and media and communications – and with an increased focus on world class commissioning, the PCT is now interested in how it can progress further, particularly in terms of community engagement and inequalities.
- 3.4. Below are some examples of how the PCT is currently targeting its services for specific groups that were visited as part of the review.

Refugees and asylum seekers – the ASSIST service

- 3.5. The ASSIST Service is commissioned by Leicester City PCT as a designated primary care centre for asylum seekers. It is one of only a few services in the UK solely dedicated to the primary health care provision for asylum seekers, who are a vulnerable, disenfranchised and excluded group.
- 3.6. Arriving in the UK with particularly complex physical and mental health needs, often the result of being tortured or raped, and with little or no understanding of the NHS, providing care for asylum seekers can be a tremendous challenge. Established in 2004, the ASSIST Service aims to meet this challenge by providing an integrated primary care service that addresses their immediate health needs and supports them in their transition into mainstream services.
- 3.7. The service provides care for over 90% of asylum seekers and approximately 65% of destitute asylum seekers within Leicester, with a further 16% receiving healthcare from GPs elsewhere. A far higher proportion of asylum seekers seek help from ASSIST than comparable national figures. This suggests that this vulnerable group see ASSIST as an accessible service with which they can engage and shows the level of trust staff at ASSIST have built up. Close working relationships with Refugee Action and the Red Cross are also a key element of the approach and ensure that those accessing the service get the support and care that they need. These three key agencies meet regularly to discuss how well the system is working.
- 3.8. The service offers registration health screening (including TB, HIV and hepatitis) and has high rates of screening uptake (cervical cytology uptake rate is 85%). ASSIST also offers a consultant midwifery service and provides help to victims of female

genital mutilation. There is in-house specialist support for patients with mental health issues and close working with the Leicester Crisis Resolution Team.

- 3.9. The service therefore fulfils a function that many GPs within the city could not. Staff have gained a specialist interest and knowledge of issues particular to this group, and have therefore developed high levels of cultural sensitivity. They are highly experienced in handling healthcare issues that relate to specifically to this group and can tailor services accordingly. Moreover, as a dedicated service, ASSIST is in a better position to facilitate appropriate language support, with many of the staff providing a multi-lingual service.
- 3.10. ASSIST was included in the 2007 European Union Best Practice document for migrant health and is currently developing a handbook for other providers on services for asylum seekers.

Gypsy and Traveller communities

- 3.11. In the past years, the gypsy and travelling community has totalled around 3,500-4000 people. The gypsy and traveling community have significantly poorer health than that of their age comparators and many suffer from chest pain, respiratory problems and arthritis. It has been recognised that the Gypsy and Traveller group have a lack of understanding of treatment available to them and because of this, conditions often become chronic.
- 3.12. As with the ASSIST service, Leicester City PCT has therefore jointly commissioned a specialist service for gypsy and travelling communities – a move that has seen significant benefits in terms of GP registration and uptake of healthcare services. The service was established in 1995 to assist and provide access to healthcare. The team consists of two health visitors, a health care assistant and an admin assistant, who cover the whole of the city.
- 3.13. Many members of this community actually have quite settled lives and travel for short periods, whereas others choose to live very mobile lifestyles which causes difficulties in accessing healthcare. Many Gypsies and Travellers also have little understanding of how the NHS works. The team therefore visits all Travellers to raise awareness of how to register with a GP or access other healthcare services; the importance of immunisation for children; and the health risks involved with smoking and obesity. The team provides advice and support, and makes referrals to other services where appropriate, for example to family planning and dental health. There is a women's group that come together at the site so the health visitors use this opportunity to talk to them about women's health and childcare needs. There are health ambassadors also now coming on board who will support the team and establish a clearer vision of the communities needs.
- 3.14. One of the Traveller sites visited as part of the peer review was a static site with a community of 21 families. Most of these families had children from the age of five to 17 years, all of whom attended school on a regular basis. There was a community centre at the site that had games for toddlers and educational books for children. .

Community Health Development Coordinators

- 3.15. The PCT has appointed several Community Health Development Coordinators, some of whom work specifically in areas where there are a high proportion of BME communities (in particular, some coordinators work specifically with the Somali and South Asian population). As such, they have developed a nuanced understanding of the health needs of these communities, and have been successful in facilitating good local engagement.
- 3.16. The peer review team spent some time with one of the coordinators and visited some of the groups he had been working with. The first of these was the Patient Participation Group (PPG) for the Cross Street GP surgery based at the Belgrave Neighbourhood Centre. The group had originally formed because of concerns about the threatened withdrawal of a service and the need for patients' views to be taken into account, and the Community Health Development Coordinator had been instrumental in helping to set the group up. This had helped people who had previously been reluctant to talk freely with GPs and other healthcare professionals to have a successful dialogue about how the practice could be improved.
- 3.17. The PPG had also branched out to do other health promotional work, including a stop smoking group set up by the Chair and education around the prevention of diabetes and managing the condition. The group had also persuaded three local temples and the Gurdwara to reduce salt and fat in the temple's kitchens. The group had also launched their own local five a day awareness raising campaign.
- 3.18. The peer review team also visited the Savera Centre – a mental health centre for people in the South Asian community and their carers. The Centre was set up in partnership with the Health Authority, Social Services and the local community in 1990 due to concerns around the lack of support for Asian people using mental health services. Savera means a New Beginning or Dawn and is unique in providing a service that promotes user empowerment in the Asian community, taking in factors such as language, religion, gender and culture into consideration. It also helps to address the stereotypes that exist in relation to mental illness within the Asian community.
- 3.19. Catering for around 40 people a day (both men and women), the centre runs a regular programme of therapeutic activities including woodwork, computing, ESOL, exercise, dance and yoga, talks on healthy food, and bingo. There is also a carers group and a CPN drop in once a month. Referrals come primarily from GPs, social services, self referral or family members.

4. KEY FINDINGS FROM THE REVIEW

Overall

- 4.1. The peer review team thought that the PCT had been very open, transparent and accessible throughout the review and within the documentation that was produced before the review. As such, the PCT had shown a real willingness to learn through the peer review process, in what was clearly a transitional phase for the organisation.
- 4.2. The team was struck by the pockets of excellent practice across the city being led by dedicated and enthusiastic individuals, and was pleased to see that these were valued by the PCT. The PCT had clearly encouraged a culture within which services like this could develop, and the team felt that the PCT now has an opportunity to support these services and move them onto the next stage.
- 4.3. The PCT had already started putting in the relevant structures needed to support this and other developments, with new appointments in public health, primary and community care, and media and communications, as well as a new equality and human rights team which includes a senior appointment working across the strategic health authority.
- 4.4. The team were particularly impressed with the finer grain evidence gained through analysis of race equality data by occupational roles, which the team thought was a really useful way of understanding a complex and varying set of needs. This is probably further advanced than many other PCTs and members of the team would be interested in following the PCT's progress in carrying out further analysis.
- 4.5. As part of the review, peers were fortunate enough to enjoy performances from pupils from Abbey School and the musicians' collective of people seeking asylum, and to visit the Peepul Centre² – a modern, community led centre and flagship regeneration project at the heart of one of the most deprived areas of the city. It was clear to the team that the PCT had a very mature and well developed partnership with the Peepul Centre and the school (although there are no direct commissioning links with the Peepul Centre).

ASSIST

- 4.6. Members of the team who visited the ASSIST service were very impressed with the quality of service that was being delivered to one of the most vulnerable groups in society. The team was particularly impressed with the dedicated staff at the centre – many of whom are multi-lingual – and felt it was clear that without their vision and commitment, the service would not have been set up and would not have achieved what it has to date.
- 4.7. It was clear from meeting staff at ASSIST that they had built up an incredibly strong level of knowledge and experience of working with asylum seekers, which had helped them to build trust over time with this group. This was an important factor in the success of the service, allowing staff to encourage patients to share their (often

² See www.peepulcentre.com for more details

horrific) stories so that they understood the difficulties they were facing and care for them appropriately. As such, the service provided at ASSIST was a very flexible, patient-led service, that was able to adapt and respond to different needs.

- 4.8. A particular strength of the approach adopted by staff at ASSIST was the multi-agency working. Staff at ASSIST had developed strong partnerships with Refugee Action and the Red Cross, with the three organisations meeting regularly to review how well the service was working. This joined-up approach seemed to work particularly well and ensured that needs were fully met. It also helped to build a shared understanding of the problems and difficulties faced by asylum seekers.
- 4.9. In addition to this, the service delivered by ASSIST was the only service for asylum seekers in the area, and as such was a genuinely unique provision. The team discussed the pros and cons of it being the only organisation delivering this service and concluded that, overall, this could be viewed as an advantage in the sense that there is a consistency of service and people are clear where and how to access it.
- 4.10. Staff at ASSIST expressed concerns about the service's future and the need for extra funding (the service is currently operating at a deficit of around £80-100,000). As such, both they and their partner agencies were keen to stress the cost effectiveness of the service and the money it saves the PCT, since most of the care is delivered in-house. This saves the PCT a great deal of money through reduced hospital admissions. Moreover, staff at ASSIST use their in-depth knowledge and experience of working with asylum seekers to provide training to other healthcare providers in the area, helping to make the healthcare system in Leicester more responsive to these needs.
- 4.11. The service has also been successful in gaining a high profile – both for the service itself and for the PCT. It has won national and international awards, and has become a model of good practice. Many of these achievements are illustrated through their Annual Reports to the PCT, which the team understood were well received.

Gypsy and Traveller service

- 4.12. This specialised service was provided by an excellent team who had been operating for 13 years. Within that time, the team had established a great deal of trust with the Gypsy and Traveller communities in Leicester, as well as a clear grasp of their needs. Baseline health needs assessments had been carried out at the static site that members of the peer review team visited, in which there were 21 families and around 50 children.
- 4.13. Members of the peer review team who visited the site and the service were very impressed by the commitment of the team, who were very dedicated to the service and clearly highly valued by the community they were working with.
- 4.14. In particular, the team had made a consistent effort to educate other healthcare professionals on the needs of this community which the peer review team thought had worked very well. They also thought that the cross agency approach was very beneficial and that the establishment of the health ambassadors would be a good opportunity to build on what is currently a relatively small team.

Community Health Development Coordinators

- 4.15. Members of the peer review team who spent time with the Community Health Development Coordinators and visited local organisations/groups that they had been working with thought that their implementation had been very useful for the PCT. The Coordinators were playing a very pivotal role, bridging the gap between the PCT and local communities.
- 4.16. The PPG had made a big difference to people's lives and the team were impressed with the way that local people had turned their anger – and a potentially negative situation – into a very positive outcome. The role of the Community Health Development Coordinator in the setting up and development of this group had been critical and it was clear that he was highly valued by the group and members of the local community.
- 4.17. The peer review team thought that one of the key achievements of the PPG was that it had begun delivering a range of services on its own initiative, including some very valuable work with the local temples on healthy eating and reducing salt and sugar in the diet. The Chair has also set up a stop smoking group and had paid for badges to promote the 'five a day' message from his own pocket, showing his enthusiasm and dedication to the group.
- 4.18. Members of the peer review team who visited the Savera Centre thought that it was an oasis of peace and tranquility, existing almost in a parallel universe in that it was not obvious that it was a mental health centre. This meant that the Centre was well used, and was reaching out to both men as well as women, which is generally not that easy for mental health services across the country. One of the main aims of the Centre was also to help people return to employment, and the peer review team were pleased to hear that staff had had success with using volunteer placements as a way of moving into employment.
- 4.19. The team picked up that staff and patients added 'Ben' or 'Bhai' to the end of their names – meaning 'sister' and 'brother' The team thought that this was quite powerful in signifying the development of health service which are culturally sensitive and subtly showed the different ethos of the Centre as a provider of innovative and welcoming health services, particularly for the local Asian community. In addition to this, the Centre Manager explained to the peer review team that they often have people turning up at the Centre asking if they can join in – evidence in itself of how well the Centre is viewed within the community.
- 4.20. The Community Health Development Coordinator's role was to act as a link with the PCT, providing support and referrals where appropriate. However, the team did not get the impression that these links were particularly strong, an issue which had already been identified by the Community Health Development Coordinator who had identified building stronger links as a key priority for the future. The Centre was, however, working closely with GPs and always made them aware of patients' attendance at the Centre in the case of self-referrals.

5. RECOMMENDATIONS FOR FUTURE DEVELOPMENT

Overall

- 5.1. The peer review team was excited by the new neighbourhood structures and the involvement of the PCT's senior management team in them, but would like to encourage members of the senior management team to go out and experience some of the projects and local communities for themselves before any further plans are made. This would be a good opportunity for some deliberate listening and a chance to build relationships, and would make an incredible difference to local communities and the PCT. The risk of not doing this is adding another layer of interventions that is probably not needed and members of the peer review team were concerned about the PCT's ability to carry out suitable impact assessments and commission relevant and responsive services without it.
- 5.2. Progress on the analysis of race equality data was impressive and the peer review team would be pleased to see the PCT take this further as planned and develop even more sophisticated data. With an energised, ambitious team, it is now time to become more robust in assessing health needs and how these relate to the commissioning strategy.
- 5.3. Given the focus on the inequality gap between Leicester and the rest of England, as well as within Leicester, a clearer process for ongoing monitoring and evaluation against a set of objectives around equality would be useful in assessing the PCT's progress and future priorities.
- 5.4. Moreover, while workforce was not the focus for the review, the PCT was honest in admitting that the senior management team is not representative so it would be good to think about what actions can be taken to address that. The peer review team recommends that the PCT integrates positive action strategies.
- 5.5. Although the senior management team is a new team, many of the frontline workers have remained, so local communities are not as aware of the PCT's 'newness' as the senior management team is. Now that the financial difficulties of reconfiguration have passed, it is perhaps time to stop calling the organisation 'new'.

ASSIST

- 5.6. Given the success of the ASSIST service and the benefits it is bringing to an extremely vulnerable group of people within today's society, the peer review team thought that a longer term strategy and more strategic planning was needed to understand where it is headed and how it fits into wider PCT thinking.
- 5.7. Moreover, the team thinks that both the PCT and staff from ASSIST should try to build better links and greater engagement with the commissioning process. When we visited the ASSIST service, staff were not really aware of the commissioning strategy and had not been consulted on it. There is an opportunity there for the PCT to draw on the specialist knowledge and experience of the service, as well as an opportunity for staff at ASSIST to become better linked in with the PCT's decision-making processes. In addition to this, staff at ASSIST could benefit from a better understanding of how to engage with PPI processes and other forums.

- 5.8. The service has clearly achieved a lot and has made a positive difference to the health and well being of a large number of asylum seekers, but much more could be done to illustrate that success in a relevant way and disseminate the learning more widely. This would help the service develop a strong business case, which should also include an estimate of the total cost the service is currently saving the PCT in hospital admissions.
- 5.9. This is important since sustainability and funding for the service was clearly an issue. The service is currently running with an £80-100,000 deficit, which the PCT might want to look at in more detail if this is a service that is clearly valued and meeting its objectives. Furthermore, there is currently some uncertainty about how the service fits with the provider arm of the PCT, so further discussions around that would be useful.
- 5.10. It was clear to the team that without the key personnel involved in setting up the service, other staff would find it a challenge to maintain the current level of service delivery. Therefore, it is worth investing in building and sharing that learning and knowledge among a wider group of staff in order to ensure sustainability.

Gypsy and Traveller service

- 5.11. Similarly, the key worker leading the Gypsy and Traveller service is eligible to retire this year, so it would be worth looking at career progression among other members of the team as well as capturing her experience and learning.
- 5.12. In terms of understanding needs, more data is needed that allows analysis by Gypsy and Traveller communities, who have traditionally been classed as 'other'. This will be important when developing the city's Joint Strategic Needs Assessment.
- 5.13. The peer review team also thought that more joint working across local organisations would be useful in addressing the broader determinants of health. For example, the site that the team visited had around 50 children, so education would be an important way of improving the health and opportunities of those children in the long term. One of the families had actually been sending 11 of their children to the local primary school.
- 5.14. A particularly challenging area for the team that requires more support and resources is around tackling entrenched attitudes within the Gypsy and Traveller community around sexual health, LGBT issues and domestic violence. A discussion with the PCT around how this can be tackled better in future would be beneficial for the team.
- 5.15. The service currently does not have a representative on the PPI or PALS forum, and it is unclear who the team is supposed to be reporting to, so greater clarity over that would be useful.

Community Health Development Coordinators

- 5.16. Given how well the Community Health Development Coordinators had been working with local communities, the peer review team thought that they actually appeared to be quite disconnected from the overall strategic planning and direction of the PCT. The

Coordinators are a key resource in understanding the communities that the PCT is serving and knowing what gaps there are, so it's important that the PCT uses them and supports them in the right way.

- 5.17. There were some tensions with the service provided at the Savera Centre in that it was dependent on social care funding but was providing a wide range of health outcomes. A previous tendering process had not been successful and the service was not being integrated within the mainstream commissioning strategy. The peer review team therefore thought that an intermediary stage might be needed to help the Centre prepare for the tendering process and build capacity among smaller organisations.
- 5.18. Moreover, there was some discussion during the review around whether the Community Health Development Coordinators should be part of the commissioning or provider arm, with a general feeling that a decision was being made towards the latter. However, the team thought that the PCT should review this decision and consider more closely the benefit of them being on the commissioning side of the organisation if one of their key roles is to provide that link to the PCT.
- 5.19. The team was very aware of the newness of many members of the PCT's management team and the challenge of tapping into and working with the rich stream of community activity that was ready and willing to assist and support the PCT. As noted above, the team therefore thought that it would be very worthwhile for the Management team and the PCT's commissioning managers to undertake a programme of listening sessions with groups such as this, which could be facilitated by the Community Health Development Coordinators. This could link directly with the new neighbourhood structures and the possibility that members of the senior management team will have a link role with each of the neighbourhoods.

Appendix 1: Peer Review Team

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The peer review team would also like to say a big thank you to the pupils of Abbey School, Sheila Mosley and the musicians' collective from communities seeking asylum for their wonderful entertainment during the review.

Appendix 3: The Peer Review Process

Peer Review visits are an opportunity for the host PCT to demonstrate their progress on one area of the programme that they are seeking to develop and to gain constructive challenge and advice from visiting PCTs.

Peer review is widely used as a performance improvement tool within government departments, local government, academia and the business world. It employs a cooperative, participatory and high-level approach that tends to be viewed more favourably by the host organisation than a formal inspection. Peer reviewers are 'critical friends', not inspectors. The review is owned by the organisation and the focus is constructive.

Peer review is conducted intensively over a short period of time, but peers are nonetheless able to offer a useful and independent assessment. The team is ideally made up of knowledgeable people working both at a senior and operational level within the sector, including those who understand the community perspective. This enables them to 'hit the ground running'; as they already understand the complexities of the operating environment and the strategic challenges facing PCTs.