



NHS WESTMINSTER PEER REVIEW: ENSURING HEALTH SERVICES ADDRESS THE COMPLEXITIES OF A DIVERSE AND CHANGING POPULATION

21/22 January 2009

Outcome Paper

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1. INTRODUCTION

The review

- 1.1. NHS Westminster hosted a Race for Health (RfH) Peer Review on 21st and 22nd of January 2009. Peer reviews are used within the Race for Health programme to share learning and good practice between PCTs, and support the host PCT to identify areas of improvement and subsequent actions in order to make those improvements. The review focused on ensuring health services address the complexities of a diverse and changing population.
- 1.2. Westminster faces a number of unique challenges:
 - It has a very challenging population. The borough's daytime population can quadruple due to visitor numbers. The borough has a very diverse and transient population;
 - NHS Westminster has large secondary and tertiary providers where change leverage can be challenging;
 - The PCT is part of strategic alliances. This offers additional challenges around delivering on equalities, due to the different equality challenges faced by partner PCTs;
 - The PCT is required to deliver equalities in the context of its commissioning relationship with Imperial College Academic Health Science Centre (AHSC);
 - The PCT has not in the past given the equalities agenda the priority it has now.
- 1.3. NHS Westminster underwent a peer review in 2005 and has seen many changes since. The PCT recognise that they are faced with a number of opportunities at the present time. They have a new Chief Executive who is very much in tune with the current public health agenda and financially the Trust is in a very healthy position. The PCT has a better understanding of what they need to do with regards to their World Class Commissioning agenda, especially in terms of structures around equality.
- 1.4. NHS Westminster has some concrete work in the pipeline around health inequalities. For example, the BME Health Forum has recently produced a report which identified barriers to GP access for some sections of the community. The PCT are beginning to work on implementing that report's recommendations with a focus on particular communities and practices which will give them hard evidence about what processes might work.
- 1.5. The PCT has London-wide alliances and local alliances with Kensington and Chelsea and Hammersmith and Fulham. It is a three-bar alliance which mirrors their provider alliance. The focus of the reconfiguration is to look for economies of scale/efficiencies of commissioning alliances across different areas (for both the provider and commissioning arms).
- 1.6. Westminster has more of a common demography with Kensington and Chelsea than Hammersmith and Fulham, for example, ethnic composition. Westminster is pushing for ethnic coding within the alliance to enable them to better reflect their diversity. There are a number of concerns that the PCT have about working within the alliance: how do they progress their equalities agenda in this context? How will they deal with the changes? How can they influence decisions? What processes and levers can they embed to help push forward their agenda? What else needs to be in place so their issues are listened to?

- 1.7. NHS Westminster is in the final stages of implementing a formal commissioning provider split i.e. autonomous providing organisation (APO). This more structured contractual model could be beneficial but this also poses a number of potential issues such as how the PCT ensures the equalities agenda is being taken care of.
- 1.8. In light of this context and in light of Westminster's very unique population structure; the theme of the peer review was ensuring health services in Westminster address the complexities of its diverse population.
- 1.9. The purpose of this outcome paper is to highlight the issues that were covered during the course of the review, and present the main findings and recommendations from the peer review team.

Key questions

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

1. Has NHS Westminster got their **overall strategic approach right**, in the context of their diverse and mobile population and are there any particular gaps?
2. Is the PCT's **approach to delivery consistent with its strategy**? What are the real challenges in getting their approach right that they need to be aware of?
3. How can NHS Westminster **deepen their understanding of the needs of their complex and diverse communities** and **how can Equality Impact Assessments (EIAs) be of benefit**?
4. What could be the **role of community intelligence** in supporting the PCT to **understand local need and getting its interventions right**?
5. How can the PCT **tailor its interventions**, especially around cardiovascular disease, to address the complex local needs?
6. What are the **best ways to measure impact** of the PCT's health interventions in the context of mobile and transient communities?
7. What are the **implications on the PCT's commissioning processes** and in particular, how can the PCT support the development of community based providers?

2. The Peer Review

Context

- 2.1 Westminster has a population of over 230,000, as quoted in the latest Public Health report. The population of Westminster is highly mobile, which is reflected in the fact that there are more people registered with Westminster GP Practices (nearly 242, 000) than are thought to be resident within the Borough. It is estimated that the weekday daytime population in Westminster may be as high as one million, all of whom are potential users of local services¹.
- 2.2 Westminster is an ethnically and culturally diverse area. It is estimated that 29% of the population belong to black and minority ethnic groups. Recently published ONS figures covering the years 2001-2006 reveal that Westminster has the highest volume of international migration per 1,000 population in England and Wales. An estimated 2,000 migrants arrive into Victoria Coach Station each week on coaches. Victoria Coach Station is one of the main points of arrival into the UK from Poland and Eastern Europe.
- 2.3 In Westminster, there is an over-representation of people belonging to BME groups among hospital admissions. For example, people belonging to Black ethnic groups are more than twice as likely to be admitted to hospital for diabetes than the population as a whole. There is some evidence to suggest that there is differential access to services between ethnic groups in Westminster. For example, comparing hospital admission rates by ethnic groups against the local profile reveals that admission rates for diabetes, chronic obstructive pulmonary disease (COPD), stroke and cancer for people of South East Asian origin are much lower than would be expected.
- 2.4 Westminster PCT came into being on 1 April 2002 and is a merger of Kensington and Chelsea and Westminster Health Authority, Parkside Health and Riverside Community Trusts and Westminster Primary Care Group. NHS Westminster's Single Equalities Scheme 2008 – 2011 was adopted by the PCT Board on 1 April 2008. The Scheme and the initial action plan published alongside it provide the framework for the PCT's approach to promoting equality in all its responsibilities - as a commissioner of services, as a provider of services, as a partner in the local economy and as an employer.
- 2.5 NHS Westminster hosted their first Race for Health peer review in 2005. The review focused on two interlinked aspects: the effectiveness of community engagement, with a specific focus on mental health services; and how feedback from community engagement can inform commissioning strategies within the PCT, and support promotion of race equality through 'managing the market'.
- 2.6 The key recommendations which came out of the peer review included: to evaluate the effectiveness of cultural diversity training for staff; to capitalize on BME community members to conduct consultation; to mainstream community and patient involvement; and to undertake more frequent and substantive community involvement by Primary Care as a whole – and GPs in particular – to help create a better understanding of issues as they are perceived by BME communities.

¹ Westminster PCT Public Health Annual Report 2006/07

Theme of the Review

- 2.7 The theme of NHS Westminster's peer review was ensuring health services meet the needs of its diverse and changing population. The peer team explored the key questions identified by the PCT through three focused areas of work: access to primary care, reducing cardiovascular disease and tools to support commissioning. The peer team was therefore broken up into three peer groups to explore each of these focus areas in detail.

1. Access to Primary Care

- 2.8 Westminster's BME Health Forum published a report in June 2008: 'Primary Concern – Access to GP Practices for Black and Minority Ethnic communities in Kensington, Chelsea and Westminster.' The BME Health Forum was co-commissioned by the PCT (with Kensington and Chelsea PCT) to carry out this piece of research to look in detail at access to GP services, to understand the barriers to access and identify how to overcome them.
- 2.9 The report highlights three main issues:
- A substantial minority group of BME communities are very dissatisfied with the process of registering with a GP and making appointments;
 - A large number of patients are dissatisfied with their relationship with their GP and practice staff; and
 - Communication problems, caused by language and cultural barriers impede on the doctor-patient relationship. Interpretation services are not widely available and waiting for an interpreter to be booked limits access to services.
- 2.12 The report made a number of recommendations to the PCT, which included: to ensure that commissioned primary care services are flexible and responsive to the needs of all groups; to undertake a full joint review to revise/establish standards for interpreting support across Kensington, Chelsea and Westminster; practices should use patient groups/panels, local community groups and the BME Health Forum should be used as a route for improving the understanding of NHS services amongst residents; and there should be active promotion of the availability of interpreting services amongst Westminster residents.
- 2.10 In this context, the first peer group visited Harrow Road Health Centre, to gain first hand experience of how a local practice is working towards improving access to primary care.
- 2.11 Harrow Road Health Centre is situated within one of Westminster's most deprived wards. Peers met with Dan Redsull, Business Manager for the Health Centre and Executive Member for the local Commissioning Cluster. The GP practice is at the heart of a local commissioning cluster made up of twelve practices.
- 2.12 At the moment, the Health Centre has around 5,000 patients on its books, with 30% of its patients changing every year on average. The Business Manager informed the peer team that the centre has an ethos of providing services to 'everyone and anyone'. The centre is located in an area of high social need. It promotes access for vulnerable groups and works with the local community. The Harrow Road Health Centre was taken over by Dr Jonathan Fluxman in 1995 who has a special interest in mental health and substance abuse.

2. Reducing Cardiovascular Disease

- 2.13 The second peer group participated in a discussion group led by Adrian Brown, Public Health Consultant for NHS Westminster. The peer group was presented with background information in relation to cardiovascular disease in Westminster and discussed the PCT's approach and how takes into account the complex needs of the local community.
- 2.14 In Westminster, circulatory diseases are the main contributors to the gap in life expectancy between the fifth least deprived and the fifth most deprived areas within the Borough – 29.5% of the life expectancy gap. The highest estimated prevalence of obesity is in the Queen's Park ward; high levels are also found in the Harrow Road, Westbourne, Church Street, Churchill and Little Venice wards.
- 2.15 Analysis of Quality and Outcomes Framework (QOF) data demonstrates that there are variations in the performance of GP practices in relation to the identification and management of people with CVD – and in the identification and management of people at risk of CVD. The number of patients registered with Westminster GP practices who have been diagnosed with hypertension is considerably lower than expected, as is the prevalence of diagnosed diabetes. Although a high proportion of patients identified on practice registers as having coronary heart disease are receiving recommended medication, a lower proportion are achieving recommended treatment outcomes.
- 2.16 NHS Westminster's approach to Cardiovascular Disease is seen as a major lever in the Trust's key priority of reducing health inequalities in the borough. The PCT has set out a vision of excellence for the prevention and treatment of CVD and aims to maximise the quality of care provided across the continuum of CVD care.

3. Tools to support commissioning

- 2.17 The third peer group participated in a discussion group led by Brian Colman, Head of Equality, Diversity and Human Rights for NHS Westminster. The peer group was presented with background information and discussed the PCT's approach to commissioning of services that meet the needs of its diverse population.
- 2.18 The peer group were provided with an overview of the tools utilised by the PCT to support the commissioning cycle. NHS Westminster has access to a range of commissioning tools, such as EIA screening tool, Race for Health Key Performance Indicators (KPIs), PPI data and Patient Experience Data. As part of the peer review process, the PCT wanted to focus on two of their key commissioning tools in particular: Joint Strategic Needs Assessment (JSNA) and the health inequalities evaluation framework.
- 2.19 Tessa Lindfield, Consultant in Public Health, gave a short presentation on the PCT's Joint Strategic Needs Assessment (JSNA). The PCT view the JSNA as a process not a document that sits on a shelf, and feel it must be jointly led by the PCT and the local authority. The JSNA when complete will cover prevention, treatment and care and will be driven by commissioning.
- 2.20 Madeleine Gabriel, Director of Evaluation for Shared Intelligence, gave a short presentation on the Evaluation Framework Shared Intelligence have developed for NHS Westminster. The Framework sets out an overall approach to evaluating NHS Westminster and Westminster City Partnership's health inequalities programme. It

identifies a set of core indicators that will show how the health inequalities programme is progressing, as well as where the data will come from.

3. KEY FINDINGS

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

Overall

- 3.2. The peer group agreed that NHS Westminster was very clear, ambitious and determined in tackling health inequalities in Westminster. Peers felt the organisation's leadership had a clear commitment to tackling health inequalities, which was particularly evident in the PCT's strategic plan. It was felt that the Trust had a real awareness of the position that they need to be in, and are well positioned to begin to deliver on their plans.
- 3.3. Peers were impressed by the PCT's clear commitment to an evidence-based approach. The peer team felt that it would now be important for the PCT to focus on how to embed this into their processes and how to make evidence-based care pathways happen. It was clear that the PCT are very committed, what perhaps was not so clear was how this will translate into making things happen. Peers felt it was important to ensure the full commitment of the Board, GPs and other partners to drive forward change.
- 3.4. The peer team agreed the PCT has some individual examples of good practice, for example, the Commissioning Decision Support Service (CDSS) was found to be a unique and innovative model. However, peers felt from what they saw, some of this good practice was not embedded in the commissioning cycle. Peers felt that it was important for the PCT to ensure the widespread use of some of their tools, such as the evaluation toolkit and the evaluation framework, and ensure staff know all that needs to be done in the commissioning cycle. Peers also felt that if the PCT develop their evaluation hub, it would put them well ahead of the game.
- 3.5. It was evident to peers that the PCT practitioners were finding it very difficult to acquire all of the information they needed from providers. It was therefore suggested that the PCT look into how they can begin to systematically acquire information by exploring potential levers. It was felt that the Trust should work towards building their confidence as commissioners to enable them to obtain the information they require from providers. This would enable the Trust to build the depth and breadth of their knowledge to gain a real understanding of their local populations.
- 3.6. The peer team felt that huge opportunities exist for the PCT to work with the third sector. Peers felt it was important for the PCT to ensure that health providers developed by the Trust will be responsive to the cultural diversity of the area. It was suggested that a way of doing this would be to build the cultural competencies of staff and local providers through a tailored training programme, which could be developed and led by the third sector.
- 3.7. Peers felt that the PCT should strengthen the support offered to the third sector. The BME Health Forum has 400 contacts that could be used for much more than meetings and consultations. For example, the PCT could use these contacts to develop outreach practices and to feed into strategy. The peer team suggested that a push is needed by the PCT in working with local communities through utilising existing local resources such as Voluntary Action Westminster (VAW).

- 3.8. The peer team agreed that it was important for the PCT to work closely with community organisations to support their capacity to delivery services, especially where local community-based organisations are assessed as the most effective route to ensure that services reach the more excluded sections of the population.

1. Access to Primary Care

- 3.9. The peer team who visited the Harrow Road Health Centre agreed that the centre was efficient and well managed and that it had a good ethos in terms of its patient led approach. It was clear that the centre recognised the health needs of the community through its open patient policy for both mental and physical support. In light of this however, peers were surprised to learn that the centre did not offer any extended opening hours.
- 3.10. The team was impressed by the conscious decision for the centre to create a diverse workforce, in particular, a dedicated Arabic speaker for two hours a day. The peer team heard that the centre's front line staff also translated for patients; however, the team had some misgivings about the extent to which this happened in practice.
- 3.11. The centre staff was found to have a clear understanding of the wider needs of the local community it serves. For example, the centre offers a range of additional services such as basic English support and employment/skills support. In fact, it was noted that the facility is becoming more of a community-based centre as it increasingly evolves to meet broader social needs. Peers were impressed by the accessibility of the services that the centre offered.
- 3.12. It was evident that the general manager was working towards improving the centre's data capture and monitoring systems. The centre has recently adapted its local patient profiling to include practical information, for example, capturing mobile numbers. The manager is also requesting evidenced-based monitoring for all new schemes to assess their impact on patients. Peers felt that the information acquired by the centre would be of value to the PCT if it was shared.
- 3.13. Peers felt that the Health Centre could potentially work more closely with the BME Health Forum, which could provide the centre with resources to understand further the outcomes of the BME Forum's research paper 'Access to GP Practices for BME Communities' and in understanding the needs of local BME communities.
- 3.14. The peer team felt that there was an opportunity for the Health Centre to work more closely with the PCT especially within the health and social care system.
- 3.15. It was felt that the PCT, working with local providers should explore ways to better track patient spread, for example to identify peaks and troughs in patient numbers from particular communities and to identify any indirect discrimination. Peers also felt that it wasn't clear how patient profiling contributes to the PCT's reducing health inequalities agenda. It was felt that the PCT should work with partners to clarify and discuss how this information feeds into strategy.
- 3.16. There were concerns by the peer team that some practices in Westminster were not open to new patients, especially vulnerable patients (not necessarily race related).

2. Reducing Cardiovascular Disease

- 3.17. The peer team felt that there was evidence of a strategic approach to the area's diverse and mobile population, and felt that the PCT's strategic plan was both robust and appropriate. Peers agreed that there was a clear link between the 'Big Killers' and specific communities, and evidence of targeted intervention, for example, Cardiovascular checks for South Asian males of over 55 years. The peer group were also impressed that the Trust's CVD plan is clearly embedded into the PCT's strategic plan.
- 3.18. Peers felt that the PCT has a clear awareness of the need for cultural competences for effective commissioning and service delivery. There was clear evidence of good local leadership from those who the peer group met over the course of the review.
- 3.19. Peers were very impressed with the PCT's Commissioning Decision Support Service (CDSS) - a body developed to build evidence from a range of stakeholders before commissioning goes ahead. Peers also fully supported the PCT with their evaluation hub concept. Peers felt that the evaluation hub concept, which will be independent of the provider, is a good way to measure impact of health interventions in the context of mobile and transient communities.
- 3.20. Peers felt that the PCT has a clear, explicit, needs led pathway for cardiovascular disease, and were happy to note that the patient journey was the determinant, not the provider. The PCT's cardiovascular plan is evidence based, and clearly recognises the need for community engagement. Equality and Diversity was well integrated into the plan.
- 3.21. It was evident that there is a commitment to a partnership working approach with the Local Authority and it was clear to peers that the PCT is ready to embrace the challenge of the commissioning alliance.
- 3.22. The peer team was positive about the PCT's flexible approach to data collection incentives, for example, LES for pharmacists. Peers felt that this was one way to help to deepen the understanding of needs of complex and diverse communities. Peers were impressed with the fact that the PCT is establishing life expectancy differentials and using these as drivers for their CVD plan; and felt the PCT has good baseline knowledge for a number of its local communities.
- 3.23. Peers were not clear about the level of GP involvement as individuals and as commissioning hubs in terms of signing up to the Equality and Diversity agenda. Peers felt that it was important for commissioning and contracting to specify the need for cultural competences and for the PCT to ensure that there is ongoing learning for all staff especially GPs (clinicians).
- 3.24. It was recommended by the peer team that the PCT fully acknowledge the importance of community engagement in terms of gaining a better understanding of who makes up the 'Other' ethnic group in the borough and identifying their health needs.
- 3.25. The peer team felt it was important for the PCT to deepen and broaden their understanding of local communities. It was suggested that this could be done by making the most of existing data sources held in house and by partners and through other means such as through the third sector; through the PCT's community engagement strategy and by encouraging PCT staff to get out in the community to enhance their local knowledge.

- 3.26. Peers felt that it could be advantageous to the PCT if a connection was made between the Expert Patient Programme (EPP) and Public and Patient Involvement (PPI) networks, for example using the experience of EPP patients to feed into the cardiovascular plan via local PPI networks.
- 3.27. It was felt that the PCT should explore means of capacity building through the third sector. Peers felt that the third sector could develop an important role in identifying key areas and feeding back to the PCT to shape health promotion activity. Peers also agreed that it was important for the PCT to support the capacity of third sector organisations to deliver services.
- 3.28. The peer team felt that it was important for the PCT to learn from existing joint commissioning experiences. It was suggested that this could be done by developing robust monitoring systems of Race Equality and cultural competences in commissioning services.

3. Tools to support commissioning

- 3.29. Peers felt that the PCT had strong joint commissioning arrangements at Assistant Director level, and felt that the PCT was well resourced. Posts included a deputy JSNA Coordinator, two posts at senior level, a Director of Commissioning and Public Health joint appointment, and a health policy and community post. This compares favourably with other PCTs in terms of resources.
- 3.30. The peer team was struck by the strong strategic approach of the PCT which reflected local challenges. There was found to be good levels of ambition and insight across the organisation. Peers also felt that there was a good understanding of the requirements to deliver, with staff having a full appreciation of the size and scale of the task. The PCT's acknowledgement of where they are now and where they want to be was felt to be strong.
- 3.31. Peers felt that the PCT's newly developed evaluation framework and guide as commissioning tools is an excellent approach and felt that the CDSS is both novel and innovative. The peer team felt that Westminster's JSNA is very comprehensive, and was robustly linked into the LAA, but what was less clear to peers is how it will link to World Class Commissioning competencies.
- 3.32. Although peers felt that the PCT's strategic vision was evidently in place, peers saw a number of strong component parts which they felt needed to be connected up. Peers felt the PCT needed to take a step back and clarify the best ways to link these elements and embed them into wide scale practices.
- 3.33. Peers felt that the PCT has a solid idea of where they need to get to in order to achieve their goals in terms of equality and diversity, but what wasn't as clear to peers was the steps the Trust needed to take to get them there, as well as how to evidence and resource developments. Peers felt that the PCT required a detailed action plan with key milestones and targets in order to begin to deliver on their plans.
- 3.34. The peer team felt that the PCT was lacking an element of innovation and risk which peers felt was necessary for the level of change the Trust wanted to make. Peers felt that the PCT could not afford to hold back especially when faced with their very different and challenging population. Peers agreed that the PCT should encourage creativity in order to address their strategic challenges.

- 3.35. Peers felt it was unclear as to how developed the third sector is in Westminster. Peers felt that the PCT should develop a package of support for third sector organisations to enhance both the provider market and commissioner confidence.
- 3.36. Peers felt that the PCT should have the confidence to acquire information in order to increase their understanding of local transient patterns and population flow. Peers felt there was different means for the PCT to access more information for intelligent commissioning, for example, visiting neighbouring boroughs such as Kensington and Chelsea to share learning and best practice.
- 3.37. Peers also felt that it was important for the PCT to obtain information that is already out there, but which may be proving difficult for the PCT to obtain, for example, patient profiles of hospital users and ethnic profile of cardiology department. Peers suggested that monies available between the local authority and the PCT should provide the necessary leverage to enable them to obtain such information.
- 3.38. It is recommended that the PCT look at the outcome of Equality Impact Assessment (EIA) screenings collectively to identify emerging trends for organisations and align EIA to the broader commissioning process. Peers also felt that it would be of benefit to the PCT if they looked into robust ways of measuring impact and worked closely with their new evaluation framework to embed this into their systems.
- 3.39. Peers felt that PCT staff need to be more flexible and responsive to their changing population, and it is therefore recommended that the organisation develops relevant training for their workforce to be able to respond to this. The workforce (both providers and commissioners) face a very specific challenge, in that they have to serve one of the most dynamic populations in the country. Peers felt that front line staff need to understand the implications of this and tailor their service accordingly.

4. RECOMMENDATIONS FOR FUTURE DEVELOPMENT

- 4.1 The peer team developed a number of key recommendations for each of the focused areas of the review. The peer team also developed a number of recommendations for the PCT as a whole, which answer the key questions the PCT posed as part of the peer review process.

Overall Recommendations

- 4.2 The PCT should develop data requirements in their acute contracts. The peer team recommended that the PCT explore how they can garner leverage in obtaining quality data for themselves and for the wider commissioning consortium.
- 4.3 The peer team agreed that the PCT should establish systems to measure providers' equality and diversity compliances to provide the level of detail appropriate for the diversity of the local population.
- 4.4 The PCT should develop robust monitoring systems, in terms of establishing outcomes and developing systems to measure progress. The new evaluation framework could go some way of assisting with this, and peers recommended that this framework was embedded in the PCT's commissioning cycle.
- 4.5 It is recommended that the PCT works closely with the local authority and potentially neighbouring local authorities, to explore the full range of data available in order to increase understanding on local population changes – including population flows and migratory patterns for certain communities.
- 4.6 Peers felt that the PCT should explore whether their local communities have a view on what service providers should look like to meet the needs of the diverse local population. The PCT could look to the third sector in partnership with the BME Health Forum to undertake such research.
- 4.7 Peers agreed it was important for the PCT to conduct or commission research into identifying the make up of the 'Other' ethnicity group.
- 4.8 The PCT should develop the capacity of the third sector to strengthen the local market – to include key components such as cultural competencies and monitoring and evaluation systems. The peer team recommended that the PCT work closely with the third sector (through the BME Forum) to explore the best ways for the PCT to strengthen their support to third sector organisations.
- 4.9 It was recommended that NHS Westminster rigorously sets out its equalities policy by embedding performance indicators and milestones in line with key recommendations set out in this document. The PCT can bring the recommendations together by agreeing and systematically assessing inputs, outputs and outcomes. This would involve setting baselines, budgets, programmes and monitoring in accordance with each recommendation they plan to action.
- 4.10 The peer team suggested that NHS Westminster evidences the change in leadership on equalities. This would involve evidencing how the Chief Executive, the Chair and the Board are working towards ensuring that the focus on reducing health inequalities (and by

association addressing the needs of BME communities in particular) is addressed in systems change, training, development and performance review.

1. Access to Primary Care

- 4.11 It is recommended that the PCT encourage the local practices, especially those who serve the needs of more deprived communities, to extend their accessibility, for example, extending their opening hours to better suit the needs of the diverse local population.
- 4.12 Collaborative working between the PCT, the BME Health Forum and GP Practices should be improved. It is also recommended that the BME Health Forum is utilised more as a resource, for example, in helping to track patients' journeys and monitoring services through review methods such as mystery shopping. It is therefore recommended that the PCT propose projects for the forthcoming year for the BME Health Forum to focus on.
- 4.13 The peer team recommended that the PCT offers customer service training to local providers, including GPs and clinicians. It was felt that there is a lot of training on offer; however, it was unclear whether there was any that had a focus on customer service. The PCT should identify whether this type of training exists and open it out to local health providers.
- 4.14 Peers suggested that the PCT provide more support to local GPs to understand why they are asked to carry out patient profiling, and how it informs health inequalities for a specific catchment area. Peers felt that this would go some way in enabling other practices to open up their lists to the PCT.
- 4.15 The PCT should provide an arena to allow high performing providers to influence other practices in the borough. At the moment, it is left to individual practices to develop and grow. For example, the GP practice at Harrow Road is very much needs focused, however, it has very normal opening hours. An arena such as a 'snapshot' peer review made up of local providers could provide an opportunity for practitioners to learn and develop.

2. Reducing Cardiovascular Disease

- 4.16 It is recommended that the PCT deepen and broaden their understanding of communities through existing data sources held in house and by partners; through communicating with the third sector; through community engagement programmes and strategy; through programmes such as 'reverse mentoring' and PCT Board walk-about monthly hosted by a community group, in order to enhance local knowledge. The peer team also recommended that the PCT tap into community members, for example, asking what it's like working/living in the local area as a community nurse/member.
- 4.17 The PCT should develop robust monitoring systems of Race Equality compliance and cultural competences for all commissioned services. This should be developed in partnership with service providers and should be communicated effectively in conjunction with a tailored training offer.
- 4.18 The PCT should ensure that all local GP's are signing up to the Trust's Equality and Diversity agenda, through contractual specifications. The peer team recommended that

the PCT should ensure that there is ongoing learning for all staff, especially GPs (clinicians) regarding cultural competences.

- 4.19 Peers recommended that the PCT explore the potential of delivering capacity building through the third sector to other third sector organisations and PCT staff (both commissioners and providers).

3. Tools to inform commissioning

- 4.20 It is recommended that the PCT work to develop and clearly demonstrate a 'golden thread' that connects its strong individual component parts into the commissioning cycle of the organisation, for example, JSNA, partnership working and procurement.
- 4.21 The PCT should inject innovation and creativity into their health strategy and interventions, in order to really make a difference in such a diverse and challenging environment. It is suggested that the PCT explore successful pilot projects, for example, from local New Deal for Communities programmes, Well London programmes, neighbourhood pathfinders and other PCTs.
- 4.22 The peer team felt the PCT should look into the support they can offer to third sector organisations in order to develop the local provider market, through such initiatives as capacity building programmes. It is recommended that the PCT work closely with the third sector to identify existing skills gaps.
- 4.23 It is recommended that the PCT incentivise the acquisition of information, especially from key providers, such as GPs and Imperial College. It is recommended that the PCT develop their confidence as an organisation to commission and to acquire information required. The peer team suggested that the PCT should exercise their power more as a commissioning body.
- 4.24 Peers suggested PCT staff make time to get out into their local community more to increase local knowledge, and visit neighbouring organisations for the sharing of learning, knowledge and best practice. The peer team also recommended that PCT staff make the most of their involvement in Race for Health, in terms of participating in peer reviews, events and networks.
- 4.25 The PCT should acknowledge the importance of acquiring different types of information to inform intelligent commissioning through developing the sophistication of information. One way of doing this would be to include equality and diversity targets in provider contracts.
- 4.26 Peers recommended that the PCT works to develop the skills of its workforce in being flexible and responsive to Westminster's changing communities, through the development of a tailored training programme. The peer team felt that as the nature of the PCT's challenge is very specific, providers and community organisations need to acquire the necessary knowledge and skills in order to serve one of the most dynamic populations in the country.
- 4.27 The PCT should look into commissioning focused pieces of research to identify potential quick, short term gains, for example, to evidence the need for an early intervention for a particular local community.

- 4.28 The peer team suggested that the PCT look into the prospect of conducting longitudinal studies with partners to identify transient and migratory patterns of certain ethnic minority and community groups. It was suggested that the PCT work alongside neighbouring boroughs to try to capture patient journeys.
- 4.29 The PCT should focus on measuring processes (theory of change) for measuring the impact of their interventions, in response to the difficulty they face in trying to capture outcomes for individuals within the context of a changing population.
- 4.30 The peer team recommended that the PCT engage with communities in a more pro-active way to better understand the transient population of Westminster and their needs in terms of local health services. It is recommended that the PCT, instead of being intent on capturing the characteristics and needs of the population in one point of time, accept that the population is changing and design services around this, so services are agile and flexible for the individual – whoever the individual may be at any given moment in time.

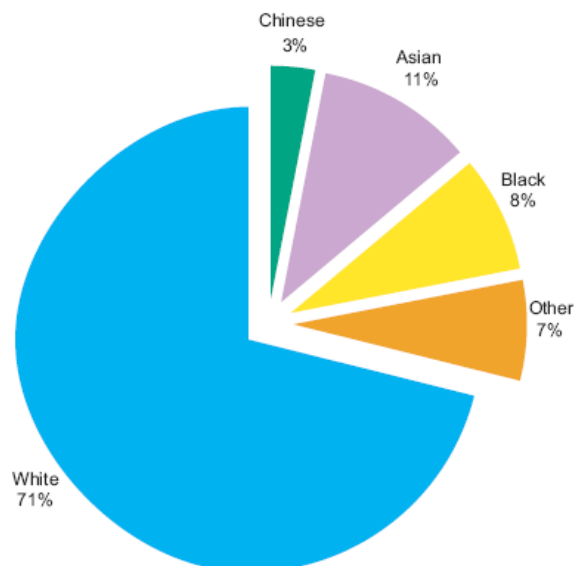
Appendix 1: Westminster's background and context

Introduction to the area: key facts & figures

- 1.1 Westminster includes some of London's most famous landmarks and districts, but also includes some of the most deprived areas in the country. According to the Index of Multiple Deprivation 2007, Westminster is ranked as the 72nd most deprived local authority out of 354 local authorities in England.
- 1.2 The population of Westminster, according to ONS population projections, was 249,600 in 2007, rising to 256,200 in 2008. The ONS projections are significantly higher than GLA projections, which estimated that there were only 213,951 people living in Westminster in 2006 and 215,286 in 2008. According to ONS, Westminster has had the greatest percentage increase in population size between mid-2001 and mid-2006 of all local authority areas nationally – a 14% increase.
- 1.3 The population of Westminster is highly mobile, which is reflected in the fact that there are more people registered with Westminster GP Practices (nearly 242, 000) than are thought to be resident within the Borough. It is estimated that the weekday daytime population in Westminster may be as high as one million, all of whom are potential users of local services².
- 1.4 The population of Westminster is distributed fairly equally between electoral wards, however, the age structure of the population varies quite considerably from ward to ward. For example, 26% of the population of Queen's Park ward is aged 0-19 years; compared to only 11% of St James's ward.
- 1.5 Westminster is an ethnically and culturally diverse area. It is estimated that 29% of the population belong to black and minority ethnic groups. It has been predicted that this proportion will remain at 29% until 2011 and will increase to 30% by 2026. A larger proportion of children and young people belong to black and minority ethnic groups (47%) compared to the population as a whole.
- 1.6 In 2007, 66% of Westminster primary school children spoke English as an additional language. For secondary school children this figure was 54%. The top five first languages spoken in Westminster schools in 2007 are shown in Figure 2.
- 1.7 Recently published ONS figures covering the years 2001-2006 reveal that Westminster has the highest volume of international migration per 1,000 population in England and Wales. Westminster is the first point of arrival for a large number of people traveling to the UK from overseas. An estimated 2,000 migrants arrive into Victoria Coach Station each week on coaches. Victoria Coach Station is one of the main points of arrival into the UK from Poland and Eastern Europe.
- 1.8 Westminster has some of the highest and some of the lowest levels of population mobility in the country. The Housing Needs Survey, undertaken by Westminster City Council in 2006, indicated that 24% of households in Westminster were seeking to move or were planning to do so within the next two years.

² Westminster PCT Public Health Annual Report 2006/07

Figure 1: Proportion of Westminster population in each ethnic group, 2008



Source: Public Health Annual Report 2006/07

Figure 2: Top five first languages spoken in Westminster schools

	Primary	Secondary	Total
English	31%	47%	37%
Arabic	20%	11%	16%
Bengali/Sylheti	11%	7%	9%
Albanian	5%	3%	4%
Unknown	1%	7%	3%

Source: Public Health Annual Report 2006/07

Health inequalities

- 1.9 The ethnic mix of the population varies across Westminster and also mirrors the pattern of health inequalities across the City. The prevalence of a number of disease and health problems varies by ethnic group – including coronary heart disease and stroke, which are major contributors to the health inequality gap observed within Westminster.
- 1.10 In Westminster, people belonging to Black ethnic groups are more than twice as likely to be admitted to hospital for diabetes than the population as a whole – 16.2% of admissions for diabetes over the period 2002-2007 were in patients of black ethnicity, compared to an estimated 7.8% in the population as a whole.
- 1.11 There is some evidence to suggest that there is differential access to services between ethnic groups in Westminster. For example, comparing hospital admission rates by ethnic groups against the local profile reveals that admission rates for diabetes, chronic obstructive pulmonary disease (COPD), stroke and cancer for people of South East Asian origin are much lower than would be expected. Overall, it seems that hospital admission rates are lower than would be expected in people of Chinese origin and higher than

expected for 'other' ethnic groups. Qualitative information from the local community about their experience of health services suggests that inequalities in access to primary care services may be making a significant contribution to this.

Figure 3: Proportion of hospital admissions by ethnic group 2002/03 – 2006/07, Westminster

Primary diagnosis	Ethnicity					
	Black	Chinese	Indian subcontinent	Other	Unknown	White
Circulatory Disease	7.6%	0.6%	4.7%	13.2%	13.7%	60.2%
Acute cerebrovascular disease	8.1%	1.1%	4.1%	9.6%	13.9%	63.2%
Coronary atherosclerosis and other heart disease	6.6%	0.5%	7.7%	17.1%	13.4%	54.6%
Acute myocardial infarction	5.8%	0.4%	7.5%	14.3%	13.4%	58.6%
Cancer (all)	8.0%	1.2%	2.6%	13.0%	14.9%	60.5%
Lung Cancer	4.1%	1.3%	0.1%	9.8%	10.3%	74.5%
Breast Cancer	9.6%	1.6%	1.5%	12.9%	9.1%	65.4%
Prostate Cancer	22.2%	0.1%	1.0%	8.7%	13.0%	54.7%
Chronic obstructive pulmonary disease and bronchiectasis	4.0%	0.7%	2.5%	8.0%	7.1%	78.1%
Diabetes mellitus without complication	19.1%	1.0%	8.0%	11.0%	14.0%	47.0%
Diabetes mellitus with complications	13.7%	0.6%	2.8%	14.3%	11.7%	56.9%

Source: Public Health Annual Report 2006/07

- 1.12 Local people identified three factors which may be contributing to poor access:
- Availability of information about what services are available, how they are organized and how they can be accessed;
 - Perceived discrimination and cultural insensitivity
 - Difficulties with English language and provision of interpreters
- These local findings echo those of recently published national reports³.

- 1.13 NHS Westminster commissioned a piece of research by the BME Health Forum, which explored BME communities' access to GP services in detail, to understand the barriers to GP access and how to overcome them. Further details of the outcomes of this report can be found in section 4 of this report. The full report 'Primary Concern – Access to GP Practices for Black and Minority Ethnic communities in Kensington, Chelsea and Westminster' published in June 2008 can be found on NHS Westminster's website.

³ Westminster PCT Public Health Annual Report 2006/07

Appendix 2: Peer Review Team

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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.