



NHS HASTINGS AND ROTHER PEER REVIEW: ACHIEVING WORLD CLASS COMMISSIONING TO IMPROVE THE HEALTH AND WELL BEING OF LOCAL BME COMMUNITIES

10/11 March 2009

Outcome Paper

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1. INTRODUCTION

The review

- 1.1. NHS Hastings and Rother hosted a Race for Health (RfH) Peer Review on 10th and 11th of March 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.
- 1.2. This review focused on ensuring health services address the complexities of a diverse and changing population. As a relatively new member of Race for Health, NHS Hastings and Rother PCT wished to ensure that its approach to World Class Commissioning would deepen and embed its approach to improving the health and well being of BME communities in the district.
- 1.3. The PCT asked the Peer Review Team to focus on the support Commissioners can give Providers in both General Practice and Community Services to identify BME groups and address their needs - a central part of the PCT's approach to World Class Commissioning.
- 1.4. The PCT also wished to consider further accountability mechanisms to ensure that Providers are delivering best practice and that Commissioners have the appropriate mechanisms in place to promote their statutory duties on equalities as part of the WCC process.

Key questions

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

1. How can the PCT support General Practices to **identify BME patient groups and address their needs in a culturally appropriate way?** (Using the key Race for Health 'pledge' groups: diabetes, coronary heart disease, stroke and mental health).
2. In the context of the Commissioner/Provider split, what are the opportunities to **improve the health of BME populations presented by the development of Provider Specifications?**
3. How can the PCT build and **sustain BME involvement** in the development of the new Station Plaza Primary Care Centre in Hastings?

2. The Peer Review

Context

- 2.1 NHS Hastings and Rother is situated on the south coast in the county of East Sussex. Hastings and Rother is predominantly a rural setting with the large towns of Bexhill, St Leonards and Hastings on the coast. There are over 175,000 residents in the PCT area, with contrasting age profiles between the two districts – a large proportion of over 65s residing in Rother and a higher proportion of under 35s living in the Borough of Hastings.
- 2.2 Overall the proportion of the population from a BME group (defined here as non white British) was just over 5% in Hastings and Rother in 2001, compared to 13% nationally. More recent estimates for 2006 show that this is likely to have grown to over 8.5%. The largest BME group in Hastings and Rother is 'White Other'.
- 2.3 Further contextual information can be found in Appendix 1.

Theme of the Review

- 2.4 The theme of NHS Hastings and Rother's peer review was achieving World Class Commissioning to improve the health and well being of BME communities in Hastings and Rother. The peer team explored the key questions identified by the PCT through three focused areas of work: access to primary care; improving the health of BME communities through commissioning; and BME involvement in the new primary care development.
- 2.5 The peer team worked in three peer groups to explore each of these focus areas in detail before discussing and comparing the common strands.

3. KEY FINDINGS

- 3.1. This section of the report details the findings of the Peer Review Team. 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.

Overview

- 3.2. It was clear to the peer review team that a **huge amount of good work has been done** by the PCT with communities and within specific communities. However, this knowledge was found to exist in separate compartments or pockets. The peer review team suggested that the PCT still needs to find the golden thread that connects up this exciting and innovative good practice, to ensure that the approaches adopted become the norm.
- 3.3. It was suggested that a key way of addressing this challenge within the PCT was to **devise a process for ensuring effective communication and knowledge sharing**; both within the PCT itself and with partners. The PCT is well placed to provide a community leadership role with organisations and groups which it funds (such as the Migrant Helpline) to gain a better understanding of the work each other is doing and to feed this knowledge back into the PCT to inform the commissioning process.
- 3.4. For example, peers who visited the Carisbrooke General Practice met a dynamic team of front line staff working with local communities. Peers felt that the **PCT should tap into the tremendous front line experience** of Carisbrooke staff and use this knowledge to help inform the design and delivery of the next generation of facilities, such as the Station Plaza development.
- 3.5. Peers underlined the **value and importance of listening to the community** to inform service design. The peer team suggested a number of ways in which the PCT could do this systematically, one of which was to commission community group(s) to research the views of specific communities. Peers recommended that the PCT look into the viability of emanating NHS Westminster's BME Heath Forum, who are commissioned by NHS Westminster to conduct pieces of research on the Trust's behalf.
- 3.6. The peer review team shared the PCT's concern that it had gaps in its current knowledge about the nature of its communities and **welcomed the PCT's proposal for a comprehensive BME needs assessment** in 2009/10 as part of its JSNA programme. Peers felt that as part of this, it would be important for the PCT to understand the distinctive communities currently categorised within its 'White Other' population. Peers suggested that this could be done by using qualitative research methods, such as focus groups with certain sections of the community.
- 3.7. Peers felt it was **important that the PCT recognised the limitations in its current data** which had informed its JSNA. It was felt that the PCT should build on the data it has to further inform its needs assessment programme. It would benefit from working closely with intermediary organisations and with education partners to pool

their intelligence. Methods such as focus groups and interactive workshops with community members, as well as front line staff, could generate rich data on the needs of different sections of the community. Peers also suggested that all **service specifications should be clear on the expectation of ethnicity data collection** as well as the PCT's own Provider services, which would enable the PCT to begin to systematically improve the quality of its data.

- 3.8. Peers were pleased **that the PCT had an agreed Equality Impact Assessment (EIA) tool**. It was suggested that the **PCT transform the way Equality Impact Assessments (EIAs) are currently used within the organisation**. Peers felt it was important for EIAs to be used proactively to shape new developments and systems, to enhance the quality of public health information and to help to prioritise Equality and Diversity within the organisation. EIAs should be adopted as a service improvement tool, so they are not only seen as a tool to risk assess, but as a positive opportunity to improve health outcomes for specific communities.
- 3.9. The peer team recognised that currently, there was **limited partnership working** between the PCT and statutory and community organisations on promoting equitable healthcare. The review team recognised that this meant working with both the district councils and the county council, and the organisations they sponsor. Peers felt there was a huge opportunity for the PCT to tap into the skills, knowledge and information held by their counterparts in the local authority and third sector.
- 3.10. The peer review team understood that there is a governance review taking place within the organisation at the moment, and peers felt that as part of this, it would be important for the PCT to clarify **where equality and diversity is located** within the new structure. The Race for Health Thinking Partner could help inform this decision by advising on approaches being adopted elsewhere.
- 3.11. The following section outlines the team's specific findings in the context of the facilities they visited and the teams they met.

1. Access to Primary Care

- 3.12. The first peer group visited Carisbrooke General Practice in St. Leonard's - an area with a high BME population. Peers were asked to explore with GPs and other Provider partners (for example, local health providers working with high need refugee families) the steps that had already been taken to identify BME patient groups and address their needs and what more could be done to improve on current practices.
- 3.13. Peers felt that the **low turnover of staff at Carisbrooke General Practice reflected positively on the management** of the centre, which was reflected in the PCT as a whole. There was evidence to suggest that front line staff worked well with Refugees and Asylum Seekers, for example, a local network and problem solving group had engaged 400 Asylum Seekers and Refugees, and as a result of consultations, access to the Practice had been improved.
- 3.14. The peer team was **impressed with the plans for the PCT's Health Trainers programme**, which was due to become operational from 1st June 2009. The team consists of thirteen individuals, equating to 5.5 whole time equivalent posts, who have been trained to provide information and support to members of the community

on public health issues and services. Peers were pleased to hear of a Russian speaking Health Trainer amongst the team who works in some of the most deprived wards in the county.

- 3.15. Peers were happy to find that there was a **core group of community members** who had been skilled up to engage and support community groups. They were found to be a group of passionate individuals who cared about their communities.
- 3.16. There was evidence that **Language Line is well used within some local Practices**. Although Language Line is available to all GPs, it didn't appear to be used by all, however, peers were happy to discover that some local GPs were on board with the service. There was also evidence of the use of face to face interpretation through South East Interpreters within some Practices; however, again this did not appear to be used across the board.
- 3.17. Peers were **pleased to meet many passionate staff** and found a willingness to explore greater connectivity between front line staff, strategic planners, community members, and statutory and voluntary partners. There was also evidence of staff taking satisfaction from improving access and patient experience and a willingness to share the learning.
- 3.18. Peers felt that there was a need to **improve the understanding of all stakeholders** about their respective roles and responsibilities and connections between all, for example, who to go to for help and advice, where levers existed for decision making, and standards and protocols to apply for commissioning opportunities. Peers found some evidence to suggest that the third sector didn't know what the PCT was doing. As such, the peer team felt that lines of communication should be improved.
- 3.19. Peers felt that **more clarity was required about needs assessment, prioritisation and funding arrangements**, for example, Refugees and Asylum Seekers with families with complex needs are sent to Hastings from all over country, but there are no links between the PCT and the Council's planning provision, specialist staff and interpretation services. The PCT need to be clearer about how they plan to meet those needs.
- 3.20. There was **evidence of the PCT linking up and sharing information** with some agencies, for example, the LINKs obtains information from the PCT about new arrivals. However, peers were unclear about how systematic this was, or whether it happened at all with other organisations and groups who would benefit from this type of data sharing.
- 3.21. The peer team found that **partnership working with the PCT and other statutory and community organisations wasn't as effective as it could be**. As such, the PCT felt that links with other organisations in the county could be strengthened, especially with East Sussex County Council, which would enable the PCT to tap into local knowledge, skills and resources.
- 3.22. Peers felt that there was a need for **clarity about where the responsibility lies for driving the race equality agenda**. The peer team suggested that the PCT sets up a stakeholder network with internal and external members (both PCT and non-PCT staff) that explore equalities issues within the organisation, which would require senior level leadership and commitment.

- 3.23. The peer team agreed that individuals working with people in the community who have very serious and complex issues should have **access to more support from the PCT** to enable them to do their job better, which includes access to local interpreters and de-briefing sessions.

2. Improving the Health of BME Communities through Commissioning

- 3.24. A discussion group took place involving a group of peers and Commissioners to explore opportunities to improve the health of BME populations presented by the development of Provider Specifications, to explore developing further the cultural competencies of Commissioner and Provider staff and improving accountability mechanisms.
- 3.25. The peer team felt that there was **evidence of commitment in parts of the organisation to tackling inequality**, e.g. LINKs, PPI, the PCT's Equality Officer, and on the Board via the Non Executive Director. Peers thought that having the Chair of the PCT chairing the Equality and Diversity Committee was good practice. The fact that the PCT was signed up to both Race for Health and Pacesetters programmes was seen to be further evidence of the organisation's commitment.
- 3.26. Peers felt there was **evidence of good PPI engagement**, and agreed it was positive that the PCT has the annual 'Closer to Home' community engagement events which were well attended (approximately 360 attendees reported at the 2008 event). The peer team felt that these events provided the PCT with a good opportunity to improve the quality of their engagement with local BME communities.
- 3.27. Peers were **encouraged that the PCT had participated in the new DES** and hoped that they would encourage 100% of GP practices to collect spoken language and ethnicity in addition to the LES. The peer team was also encouraged by the improvements in acute data collection.
- 3.28. Peers were **impressed with the PCT's plans to pilot a Commissioning Data Warehouse** model. This system will house primary care service data from GPs, hospitals, and mental health services in a single database allowing users to cross refer and correlate information. The system is being developed this year in partnership with West Sussex PCT. Peers felt this model was a **pioneering and innovative exercise**.
- 3.29. Peers felt the PCT was **doing good work on collecting ethnic minority data of its workforce**, but were unclear as to what the total completion rate was. If the latest figures presented to the peer team were a total of the whole workforce, the peers were pleased by the levels of completion of this data, but peers felt this needed clarification.
- 3.30. It was felt by the peer team that the **Equality and Diversity Committee should be reviewed**. For example, it was felt that clarification was needed on its terms of reference and peers felt there was a need for the Committee's remit to incorporate commissioned services.

- 3.31. The peer team felt it was **important for more than one representative from Public Health to sit on the Equality and Diversity Committee**. Peers also felt that it would be very important for the PCT to be clear on who will drive forward the Race for Health agenda when the current lead officer leaves the organisation.
- 3.32. Peers felt that the PCT's system of using **EIAs needed to be strengthened**. At the moment, peers were worried that it was viewed as a negative process and felt that there was an opportunity for the organisation – led by Directors – to turn this around. The peer team agreed that the EIA process could be viewed as a much more positive exercise, and an integral part of ensuring better health outcomes for some communities.

3. New Primary Care development at Station Plaza

- 3.33. The Peer Review Team was asked to explore with partners ways of building BME involvement in the development of the new Station Plaza Primary Care Centre to influence its future impact on the local community. The development is the first of three new integrated facilities planned within Hastings and the advice given would also be of use in those developments.
- 3.34. Station Plaza is a Primary Care development, under construction which will house five separate GP practices and a Walk In facility, due to be completed in March 2010. The development is on a prestigious site at the top of the town adjacent to Hastings College. The Station Plaza project team was seeking to build and sustain excellent relationships with the BME communities in Hastings Town Centre.
- 3.35. There is a **vibrant Station Plaza user group in existence** and mechanisms are in place to engage with local communities. However, it has proved difficult to engage specifically with the BME community in the new development to date, which led to the PCT requesting support from the peer team in thinking through new approaches to engage certain sections of the community.
- 3.36. Peers met with colleagues from within the PCT's Business Change and with colleagues from the PCT, District and County Council's community involvement and cohesion teams to discuss how the project team can better engage BME communities in the development of the centre.
- 3.37. The peer group felt that **opportunities still existed for the PCT to engage local BME communities** in the Station Plaza development, and the PCT should not feel that they have 'missed the boat' Whilst the core design was set it should still be possible to involve people from BME communities in the in plans for the delivery of the centre. The PCT should look at how best they can involve people to ensure they set up the walk in centre so it does address the health needs of all sections of the community. The PCT should also ensure that their other planned health centres are influenced by what has been learned from the Station Plaza development.
- 3.38. There was evidence that **PPI has been successful in attracting community members with first hand knowledge of disability issues**, who were committed and enthusiastic about the project. Their input had directly influenced the design of Station Plaza. Peers felt that the PCT now needed to reformulate the PPI group, as it was felt that different issues needed to be explored with a different representative group with more BME involvement.

- 3.39. The **Equality Impact Assessment screening of the Station Plaza was found to be based upon limited evidence**, and peers felt it missed a number of equality issues and implications. Peers suggested it was difficult to assess the development as a whole, and recommended that the PCT conduct a staged EIA process – so that the consultation stage, design of the building, patient flow and management, construction of the building, and access to the facility were assessed separately.
- 3.40. Peers were advised that the Station Plaza development would be largely staffed from within existing GP practices but that there would be some generic staff e.g. reception. It was suggested that the PCT firstly **ensure a representative PPI group, and use PPI members to help to develop job descriptions**, which would help to ensure that front line staff have the right competencies to meet the needs of local communities. It could also help to address the current problem with the instability of current job roles and staff. The PCT could also look into the viability of using local volunteers in the centre.
- 3.41. The peer group were concerned that the PCT and centre staff had **not yet considered how patients will 'flow' through the Station Plaza building**, for example, considering appropriate signage for patients facing language barriers. Peers had experience of other facilities using 'greeters' to help people navigate through the building, particularly in the early stages of the facility opening to the public. The Peer review group is pleased to note that the 'flow' of patients through Station Plaza is already being discussed by the Station Plaza Health Centre Project Group and user group – and hopes it will be possible to do some customised focus group work with BME communities specifically to complement this work .

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 peer review team recommended that the PCT works towards **connecting up its areas of good work**, and maximises opportunities for organisations to work together to share learning and good practice, through staff networks.
- 4.3 Peers felt it was important for the PCT to **provide opportunities to listen to its communities** more. It was recommended that the PCT should look to develop a BME Heath Forum (similar to NHS Westminster's model) which could be commissioned by the PCT to conduct research on its behalf. This suggestion has been initially welcomed by NHS Hastings and Rother.
- 4.4 It was recommended that the PCT work towards **developing its data collection methods**. Peers felt that an important area for the PCT to concentrate on was disaggregating its 'White Other' population to find out which communities make up this category. It was also recommended that the PCT use more qualitative data collection methods to further inform its JSNA, for example, focus groups with specific ethnic communities. It was also suggested that all service specifications should clearly express the PCT's expectation for ethnicity data collection.
- 4.5 The peer review team strongly suggested that the PCT **strengthens and develops its Equality Impact Assessment process**, and recommended that it engages local communities in how the tool can be used to assess impact. It was recommended that EIAs are used proactively within the PCT's planning cycle to shape new developments, to transform the way the tool is viewed – as a positive mechanism to improve the health of specific communities. It was recommended that this should be driven by strong leadership at Director level.
- 4.6 Peers recommended that the PCT work towards **improved partnership working** with the local authority and other statutory and community organisations across the county to **share knowledge, information and data**, utilise skills of counterparts in other organisations and explore the possibility of pooling resources on some joint pieces of work, such as research or BME engagement.
- 4.7 It was felt that the PCT should work on **improving their methods of communication** with both its staff and with the local community. This could be providing key documents in different formats, workshops for different BME communities with interpreters, and the development of a social marketing toolkit with the aim of engaging and building the confidence of the local BME community.
- 4.8 Peers recommended that the PCT **clarify who will champion the wider equalities agenda** within the organisation's new governance structures. The peer team suggested that the PCT discuss with their Thinking Partner such things as: clarity of ownership; whether they are best served having one equalities sub group or more;

and where Equality sits - in Commissioning, Provider function or Public Health. The peer group felt that the PCT's equality agenda could be strengthened and better coordinated across the organisation.

- 4.9 It was recommended that the PCT continually **recognises and stimulates the third sector**. The peer review team agreed that it was important for the PCT to recognise the value of those people who are working with communities and works towards supporting those individuals, such as access to translator services and support in responding to Commissioner contracts. It was also recommended that the PCT recognise the level of knowledge and expertise some front line staff have, and ensure that local intelligence is fed in to the PCT's decision-making processes.
- 4.10 **Race for Health are in a position to provide help and support** to NHS Hastings and Rother. There is a lot to be gained from Race for Health family members who have real experiences for the Trust to draw upon. There are many opportunities for members to share experiences and transfer learning through networks, events, and informal processes.

1. Access to Primary Care

- 4.11 Peers suggested that the PCT should **consider the establishment of a cross agency BME network** for people working on BME issues with clear reporting arrangements to feed into the strategic planning process. There was evidence of this being done to a degree, however peers felt it needed to be broadened and strengthened and pulled together so it can influence where decisions are made.
- 4.12 It was recommended that the PCT **use the Practice Manager's Forum and other groupings to share good practice**, learning and problem solving in relation to improving health outcomes and access for BME communities.
- 4.13 Peers suggested that the PCT **explore mechanisms for assessing staff and organisational cultural competences** and ways of driving this up where appropriate. It was suggested that this would require robust assurance mechanisms from the top of the organisation.
- 4.14 Peers felt that the PCT should **use the personal testimony of people from BME backgrounds and frontline staff** working with them **to inform training and development for all staff and strategic planning**. At the moment, health professionals have no mechanisms in which to collate the views of BME patients on their experiences of care. This intelligence should be systematically fed into decision making and a training and development programme for staff. Peers felt this would be a good way for the practice to engage its communities and influence the PCT.
- 4.15 The peer review team felt that the PCT should also **identify and utilise health care experience** from elsewhere, for example, among the Refugee and Asylum Seeker population.
- 4.16 It was recommended that the PCT **audit and collate information on who is doing what in the local area**, for quality assurance and to share best practice.
- 4.17 It was recommended that the PCT **improve partnership working with primary and secondary Providers and partners** (statutory and third sector) to share local

knowledge and information, and to explore ideas for future joint initiatives to meet the needs of specific sections of the community.

- 4.18 The peer team recommended that the PCT **provide more information and support to all stakeholders**, such as information on who to contact within the PCT for support and advice, standards and protocols, guidance for interpretation services, commissioning opportunities, local provision and community expectations.
- 4.19 Peers suggested that it could prove advantageous for the PCT to **stimulate the local market in terms of future health Providers**. It was suggested that there can be some health professional amongst BME communities and the PCT should explore pathways into employment for BME communities, and ways of identifying and harnessing existing skills.

2. Improving the Health of BME Communities through Commissioning

- 4.20 It is recommended that the PCT **make a commitment on who will take forward the equalities programme**, including the recommendations from this paper. Peers recommend that this report is taken to the Equality and Diversity steering group and the Trust Board for consideration and agree an action plan to respond to the recommendations which should then be published on the PCT's website.
- 4.21 The PCT should **review the terms of reference of the Equality and Diversity Committee**. Peers felt that the Committee need a focus on commissioned services, ensuring equality and diversity is embedded within commissioning. The peer group also suggested that the Committee develops a work programme which is agreed and monitored by the Board.
- 4.22 It was suggested that the PCT **considers having two separate Board committees for equality and diversity**, as the PCT has two separate Boards and two very different areas and therefore priorities for equality will be different. Peers felt that this might assist in keeping equality issues higher on the agenda for Hastings and Rother.
- 4.23 Peers recommended that the PCT **take advantage of local BME events** that take place in the county in terms of public engagement to inform service redesign and other priorities, such as Refugee Week and Hastings Intercultural Day. The peer group felt that the PCT needed proper resources for effective engagement, for example, translation of key documents and interpreters.
- 4.24 It was felt that a strong **leadership drive was required to turn the EIA agenda around**, from something that is perhaps perceived as a negative process to one which is positive and drives forward improved health services. It was recommended that work is done to change common perceptions from something that staff perhaps feel has to be done from fear of litigation, to a tool that is seen as a driver for more positive outcomes for certain communities.
- 4.25 The peer group strongly recommended that **EIA is carried out early on in the decision making process, and is a process which should engage communities**, and should be used alongside needs assessments to inform strategy and planning.

It was suggested that the PCT look into training champions so more people can be involved in EIAs.

4.26 It was suggested that the PCT **prioritise some of its key projects and processes for an equality impact assessment**, for example, the PCT's community engagement strategy and the 'Closer to Home' event, which peers agreed would assist in ensuring the PCT were successfully engaging with all sections of its local community.

4.27 Some peers questioned the joint reviews conducted by the PCT and the local authority using the joint EIA impact assessment toolkit, as it was felt that the health component could potentially 'get lost' in such a broad venture. It was therefore recommended that **on completing a joint impact assessment, the PCT should consider developing a separate action plan** setting out their respective organisational responsibilities.

4.28 The peer team recommended that the PCT work to **improve its methods of data collection and reporting**, which included:

- Using more up-to-date data especially on profiling, across the board. This would enable the PCT to update its Single Equality Scheme and strategic plans, which would help the Trust define priorities and raise Equality up the agenda;
- Amending the PCT's data collection template, to include 'White Other' sub categories;
- Clarifying the PCT's definition of BME (non-White or non-White British) and ensuring that this definition is used consistently throughout the organisation;
- Clearer presentation of data in key strategic documents, including source, date and base numbers;
- Completeness of data (90%) in Provider arm should be built and monitored into service specification;
- Offering training for front line staff on how to 'ask the question' on ethnicity to develop Practice profiles. This information should be systematically fed back to the PCT;
- Some PCTs have found it helpful as part of their workforce data to collect length of time in grade, as it shows how many people are progressing in the organisation;
- Inclusion of non-White British within the population breakdown in workforce data, and inclusion in service specifications/SLA so that all services reflect the population;
- Using the support from Race for Health network to identify appropriate support and good practice in terms of data collection;
- Using qualitative information in needs assessments;
- Not waiting for the data to become available to take action.

- 4.29 Finally, the peer group recommended that the PCT should explore the prospect of **growing new Providers from the third sector**.

3. New Primary Care Development at Station Plaza

- 4.30 It is recommended that the PCT build on existing community resources to **improve their process of engagement with the community**. For example, the Gypsy and Traveller project, the BME practitioner forum, the Health Trainers and the Community Development Workers could all be tapped into.
- 4.31 It was recommended that the PCT **develops partnerships with intermediate third sector organisations** to assist with engagement and involvement of BME communities. The peer group also felt that the PCT should grow the number of their Community Development Workers from BME communities.
- 4.32 By **working with partners** such as the Police, East Sussex County Council, BME practitioners, local schools etc, a wealth of data could be obtained for increased knowledge of the local population which could be used as a basis for partnership working on health inequalities, especially for targeted interventions.
- 4.33 Peers recommended that the PCT **build on what can be achieved for Station Plaza**. For example, the PCT could engage with the BME community to shape projects that can be delivered from the centre, and to inform internal design, such as the design and placement of signage and use of symbols. It was also recommended that within the centre, the PCT and centre staff work with a focus on culturally competent patient journeys.
- 4.34 It was suggested that the PCT **consider a staged approach to increasing engagement**, for example, engaging service users/community representatives in the governance review, organising an open day for when the Station Plaza centre opens, combining the centre opening with a cultural event to provide an opportunity to consult on service provision and initial feedback.
- 4.35 The PCT could think about having **sub-groups linking in with PPI that focus on specific issues/sections of the community**. Peers felt it important that the PCT get the right level of engagement with the community – not through letters or leaflets, but through combining engagement with cultural food and music events.
- 4.36 The Trust could benefit from winding up the existing PPI group concerned with the Station Plaza Project, as it has mostly been involved with the design and building of the Centre and isn't as representative as it could be. It was suggested that the Trust **forms a new PPI group that would be concerned with the implementation of the new Primary Care centre** and access to the various services. This would be an opportunity to stage community engagement events using methods that enable the Trust to meet the community face-to-face.
- 4.37 The peer team recommended that a **staged Equality Impact Assessment (EIA) is carried out for the Station Plaza development**. This would involve an EIA being undertaken separately for the consultation stage, design of the building, patient flow and management, construction of the building, and access to the facility. An EIA

screening document exists, however, the evidence on which it is based could be improved. It was felt that the PCT could benefit from more support and guidance on bringing their EIA process to life.

- 4.38 It was suggested that **patient involvement is developed for the design of the job descriptions for the Station Plaza** and other buildings. This would provide an opportunity for the PCT to recruit staff with specific skills, such as actively recruiting front line staff who could deal with language barriers.
- 4.39 In terms of staffing within the Station Plaza, it is recommended that the PCT work to **increase the stability of the existing job roles**, as the peer group noted that there was a high turnover of staff. One way of doing this would be for the PCT to work with existing Station Plaza staff and local communities to **develop or shape a training plan** linked in with job descriptions for frontline staff. Peers also recommended that **local volunteers are used within the centre**.
- 4.40 It was recommended by the peer group that the PCT works towards **coordinating initiatives on health inequalities** data (with BME practitioner group, East Sussex County Council, Public and Patient records capture, language needs), and integrate the evidence to build on the gaps that currently exist in the data.

Appendix 1: Response from NHS Hastings and Rother

Following the receipt of the draft outcome paper, NHS Hastings and Rother provided responses to some of the points raised within the document:

- In parallel to the site visits as part of the peer review, the EIA process was being reviewed and linked to service improvement in addition to risk and, following the visit, these recommendations were agreed by the PCT and the process is being implemented this year.
- The PCT have made the decision that the overall lead for the equalities agenda remains as a corporate function, with an E&D sub-committee. Race for Health and Pacesetters have a separate steering group that feeds into this and identified leads from each PCT directorate support and champion this. The terms of reference for this group have been reviewed and strengthened following the governance review.
- The PCT recognise the importance of public health with respect to the equality and diversity agenda but need to balance representation at meetings with capacity and appropriateness of additional representation.
- NHS Hastings and Rother recognise that further awareness raising with local practices needs to take place with regards to available interpreting services. The PCT is also developing fact sheets and training packs and a resource pack for frontline staff to support work around health needs of asylum seekers and refugees, migrants, excluded groups, homeless families and gypsies and travellers.
- The 'flow' of patients through Station Plaza, as recommended by the review team as something which could be looked into, is being discussed by the Station Plaza Health Centre Project Group and user group.

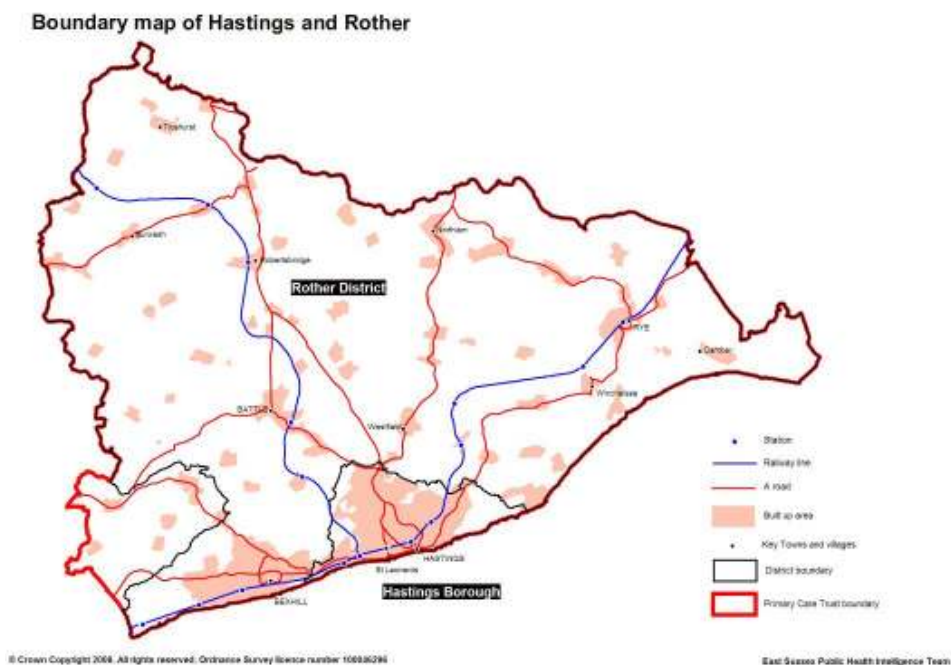
The PCT invited their new Thinking Partner (Teresa Edmans) and the Lead Facilitator of the RfH Learning Programme and Managing Director of Shared Intelligence, Sue Charteris to NHS Hastings and Rother's Equality and Diversity Committee in July 2009. The Committee had internally discussed how best to take forward the recommendations and had developed a draft action plan prior to the committee meeting. The recommendations from the peer review and the draft action plan were discussed at the meeting and following this, the action plan was finalised and will be included as part of the PCT's Single Equality Scheme action plan refresh.

The Peer Review team very much welcome the PCT's commitment to the outcomes of the review, and the dedication the PCT has demonstrated in following up on the recommendations through an action plan which will be integrated within their Single Equality Scheme.

Appendix 2: Hastings & Rother's Background and Context

Introduction to the area: key facts & figures

NHS Hastings and Rother is situated on the south coast in the County of East Sussex. The Primary Care Trust area contains two Local Authorities, Hastings Borough Council and Rother District Council, along with one electoral ward from Wealden District Council in the South West of the area. Hastings and Rother is predominantly a rural setting with the large towns of Bexhill, St Leonards and Hastings on the coast.



There are over 175,000 residents in the Primary Care Trust area. What is particularly contrasting between the two districts within the area is the large proportion of over 65s residing in Rother and the higher proportion of under 35s living in the Borough of Hastings.

Mid-2007 resident population estimates

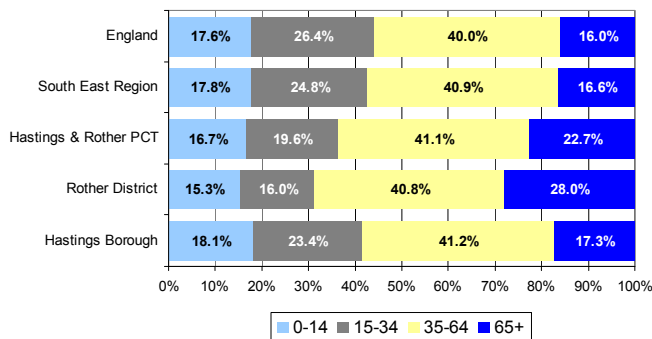
Source: www.nchod.nhs.uk, January 2009

	Hastings Borough		Rother District		Hastings & Rother PCT		South East Region		England	
	n	%	n	%	n	%	n	%	n	%
0-14	15,593	18.1%	13,461	15.3%	29,417	16.7%	1,475,687	17.8%	8,999,193	17.6%
15-34	20,200	23.4%	14,119	16.0%	34,579	19.6%	2,062,085	24.8%	13,481,278	26.4%
35-64	35,504	41.2%	35,972	40.8%	72,512	41.1%	3,394,598	40.9%	20,452,216	40.0%
65+	14,922	17.3%	24,664	28.0%	40,070	22.7%	1,376,280	16.6%	8,159,345	16.0%
Total	86,219	100.0%	88,216	100.0%	176,578	100.0%	8,308,650	100.0%	51,092,032	100.0%

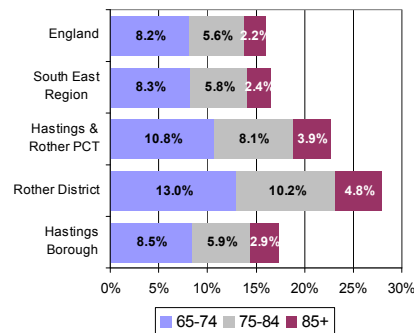
Over 65's breakdown

	n	%	n	%	n	%	n	%	n	%
65-74	7,291	8.5%	11,445	13.0%	18,999	10.8%	688,184	8.3%	4,192,458	8.2%
75-84	5,099	5.9%	9,003	10.2%	14,249	8.1%	485,700	5.8%	2,864,879	5.6%
85+	2,532	2.9%	4,216	4.8%	6,822	3.9%	202,396	2.4%	1,102,008	2.2%

Age distribution, mid-2007



Distribution of persons aged over 65s, mid-2007



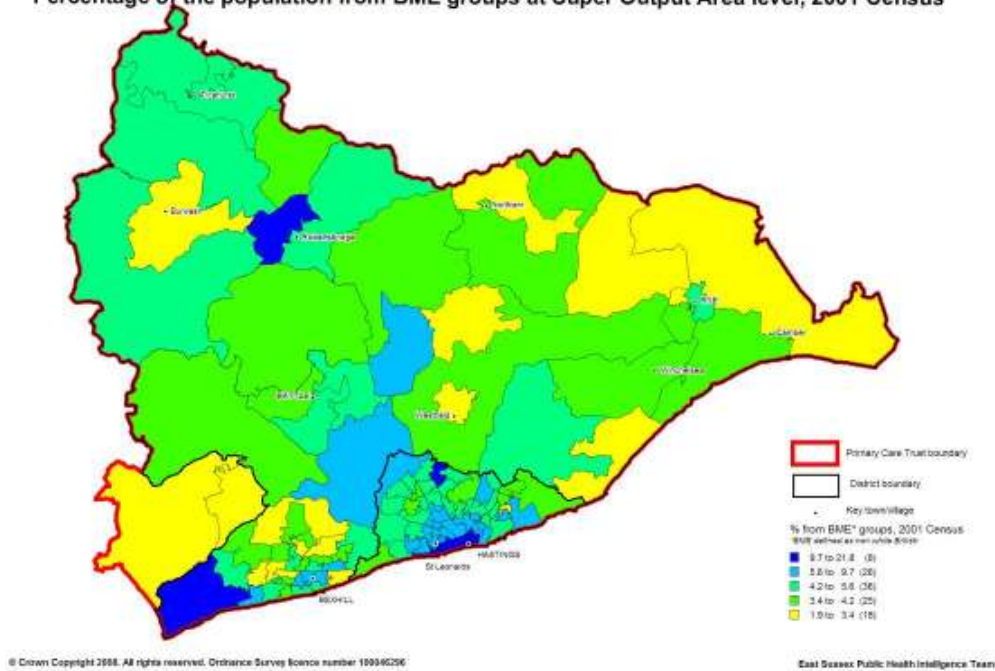
Overall the proportion of the population from a BME group (defined here as non white British) was just over 5% in Hastings and Rother in 200, compared to 13% nationally. More recent estimates for 2006 show that this is likely to have grown to over 8.5%. The largest BME group in Hastings and Rother is 'White Other'. The full breakdowns are shown in the table below.

The most recent ethnicity data at a local level are from the 2001 Census. The SOAs with the higher proportion of the population from BME groups are concentrated around Hastings, St Leonards and Bexhill. There are a few exceptions such as the Darvell Community, a distinctive religious community, with an Anabaptist heritage dating back to the 16th Century that is clustered around an independent school in Robertsbridge. There is also a United Arab Emirates Technical Training Campus that accounts for the large proportion of the BME community to the west of Bexhill.

Ethnic breakdown of Hastings and Rother's population

Ethnic Group	Hastings Borough		Rother District		Hastings & Rother PCT		South East Region		England	
	2001	2006	2001	2006	2001	2006	2001	2006	2001	2006
White: British	94.09	90.13	95.39	92.69	94.74	91.42	91.30	87.91	87.00	84.19
White: Irish	0.95	0.93	0.75	0.80	0.85	0.86	1.00	1.01	1.30	1.15
White: Other White	1.98	2.90	1.97	2.40	1.97	2.65	2.80	3.65	2.70	3.35
Mixed: White and Black Caribbean	0.38	0.46	0.14	0.23	0.26	0.35	0.30	0.39	0.50	0.54
Mixed: White and Black African	0.17	0.23	0.08	0.11	0.13	0.17	0.10	0.18	0.20	0.21
Mixed: White and Asian	0.42	0.58	0.2	0.34	0.31	0.46	0.40	0.49	0.40	0.49
Mixed: Other Mixed	0.32	0.35	0.2	0.34	0.26	0.35	0.30	0.38	0.30	0.40
Asian or Asian British: Indian	0.37	0.81	0.2	0.68	0.29	0.75	1.10	1.59	2.10	2.49
Asian or Asian British: Pakistani	0.07	0.35	0.02	0.23	0.05	0.29	0.70	0.91	1.40	1.70
Asian or Asian British: Bangladeshi	0.13	0.23	0.09	0.11	0.11	0.17	0.20	0.29	0.60	0.67
Asian or Asian British: Other Asian	0.17	0.35	0.13	0.34	0.15	0.35	0.30	0.47	0.50	0.64
Black or Black British: Caribbean	0.22	0.58	0.07	0.34	0.14	0.46	0.30	0.53	1.10	1.17
Black or Black British: African	0.21	1.05	0.11	0.57	0.16	0.81	0.30	0.79	1.00	1.37
Black or Black British: Other Black	0.05	0.12	0.01	0.00	0.03	0.06	0.10	0.11	0.20	0.22
Chinese or other ethnic group: Chinese	0.21	0.35	0.16	0.34	0.18	0.35	0.40	0.67	0.40	0.74
Chinese or other ethnic group: Other ethnic group	0.26	0.58	0.48	0.46	0.37	0.52	0.40	0.63	0.40	0.69
Summary										
BME*	5.91	9.87	4.61	7.31	5.26	8.58	8.70	12.09	13.10	15.81
White	97.02	93.96	98.11	95.89	97.56	94.93	95.10	92.57	91.00	88.68
Mixed	1.29	1.63	0.62	1.03	0.95	1.32	1.10	1.44	1.40	1.63
Asian or Asian British	0.74	1.74	0.44	1.37	0.59	1.55	2.30	3.26	4.60	5.49
Black or Black British	0.48	1.74	0.19	0.91	0.34	1.32	0.70	1.43	2.30	2.76
Chinese or other ethnic group	0.47	0.93	0.64	0.80	0.55	0.86	0.80	1.30	0.80	1.43

Percentage of the population from BME groups at Super Output Area level, 2001 Census



Race for Health Key Performance Indicators (KPIs)

Diabetes

In 2007/08 there were over 7,000 people on a Diabetes register in Primary Care within Hastings and Rother. This accounted for 4.1% of the population registered with a GP compared to 3.9% overall for England.

According to the Yorkshire & Humber Public Health Observatory PBS prevalence model based on Census 2001 population data, it has been estimated that people from a Black or Asian background have a higher prevalence of Diabetes than people from a White background.

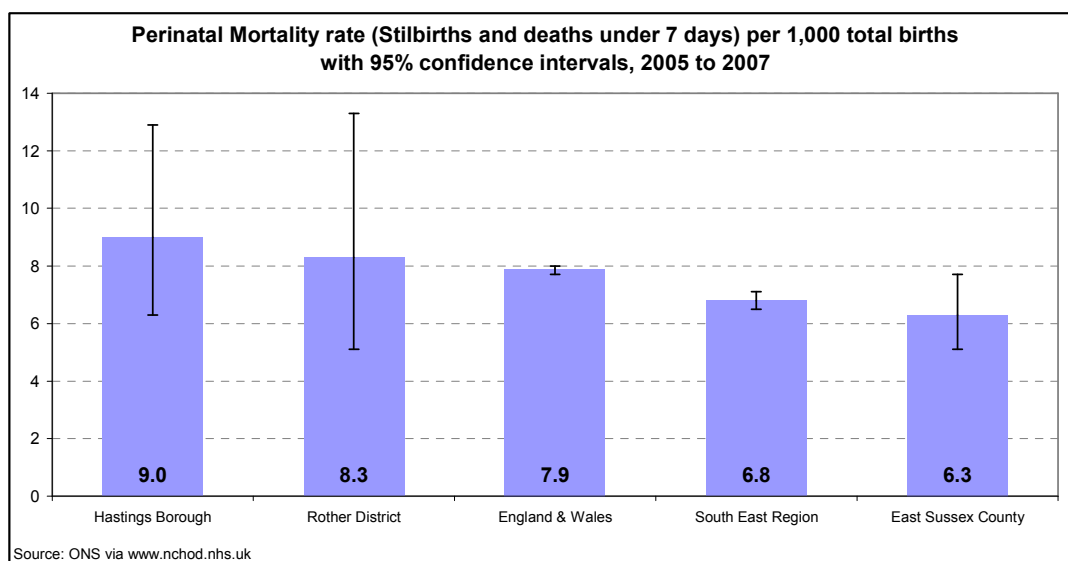
Estimated number and prevalence of Type 1 and Type 2 Diabetes (diagnosed + undiagnosed) by ethnic group, 2001

Area	White	Black	Asian	Other
England	4.2%	5.6%	6.6%	2.1%
South East Region	3.8%	5.2%	6.1%	1.9%
Hastings Local Authority	5.0%	8.7%	8.6%	2.8%
Rother Local Authority	5.7%	7.1%	9.0%	1.4%

Source: http://www.yhpho.org.uk/PBS_diabetes.aspx

Perinatal Mortality

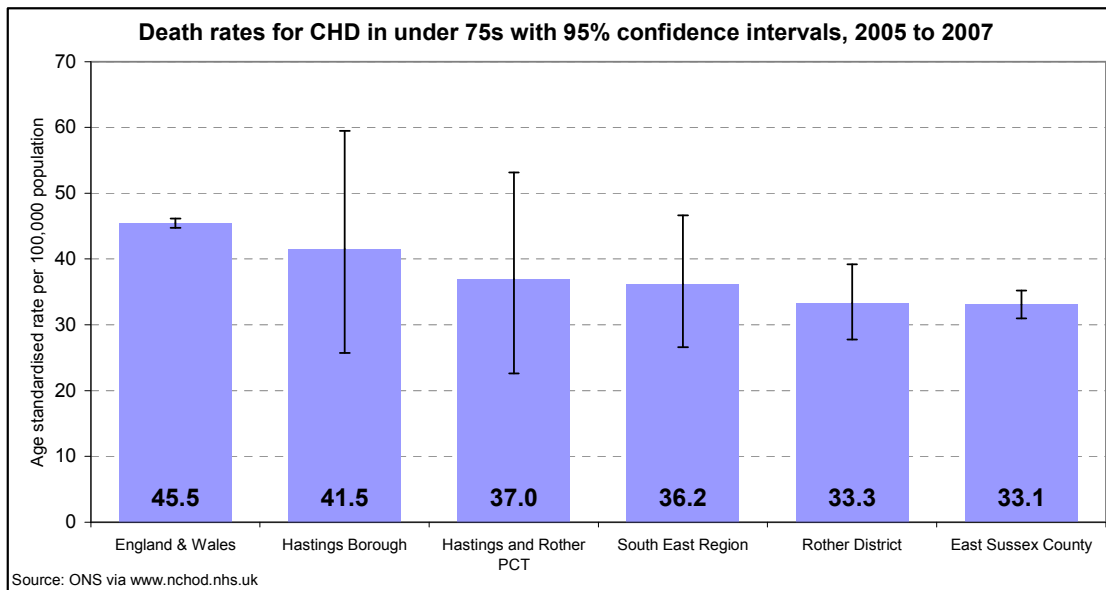
There were fewer than 50 perinatal deaths (stillbirths and deaths under 7 days) across Hastings and Rother between 2005 and 2007. Whilst the rates were higher than the national and regional figures these differences are not statistically significantly higher, due to the small numbers involved.



Coronary Heart Disease

Just over 7,500 people were identified on a CHD register in 2007/08 within Hastings and Rother PCT area. This accounted for 4.1% of the population registered with a GP compared to 3.5% overall for England.

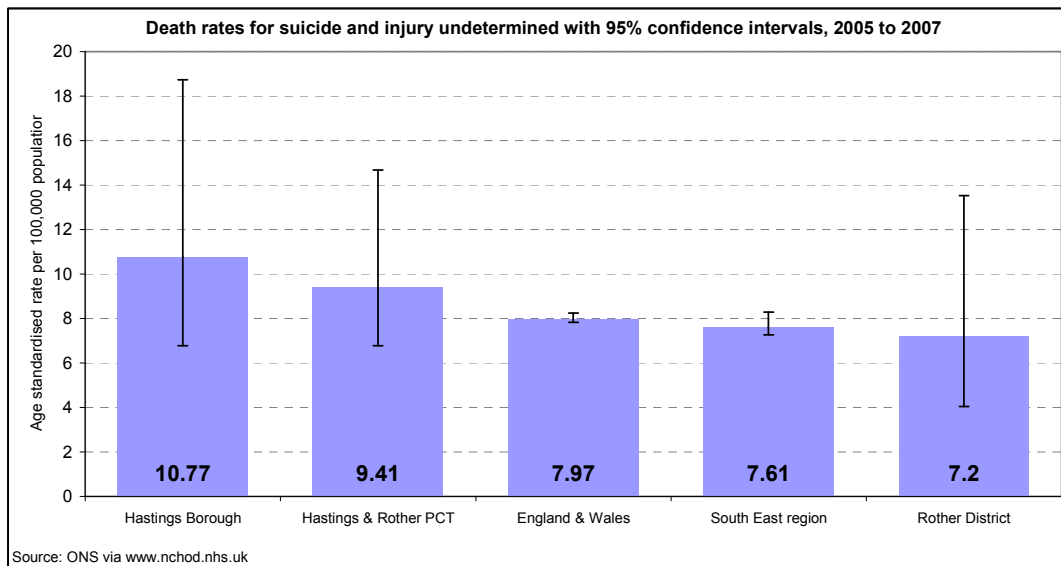
Between 2005 and 2007 over a thousand people died from CHD. Around a quarter of those deaths were to people aged under 75. Death rates from CHD for under 75s are below the national average but above the regional average.



Mental Health

Over 1,600 people were identified on mental health registers in Primary Care in Hastings and Rother in 2007/08.

There were just under 60 deaths from suicide and injury undetermined in Hastings and Rother between 2005 and 2007. Rates were higher within Hastings compared to England and Wales, however these were not statistically significantly higher.

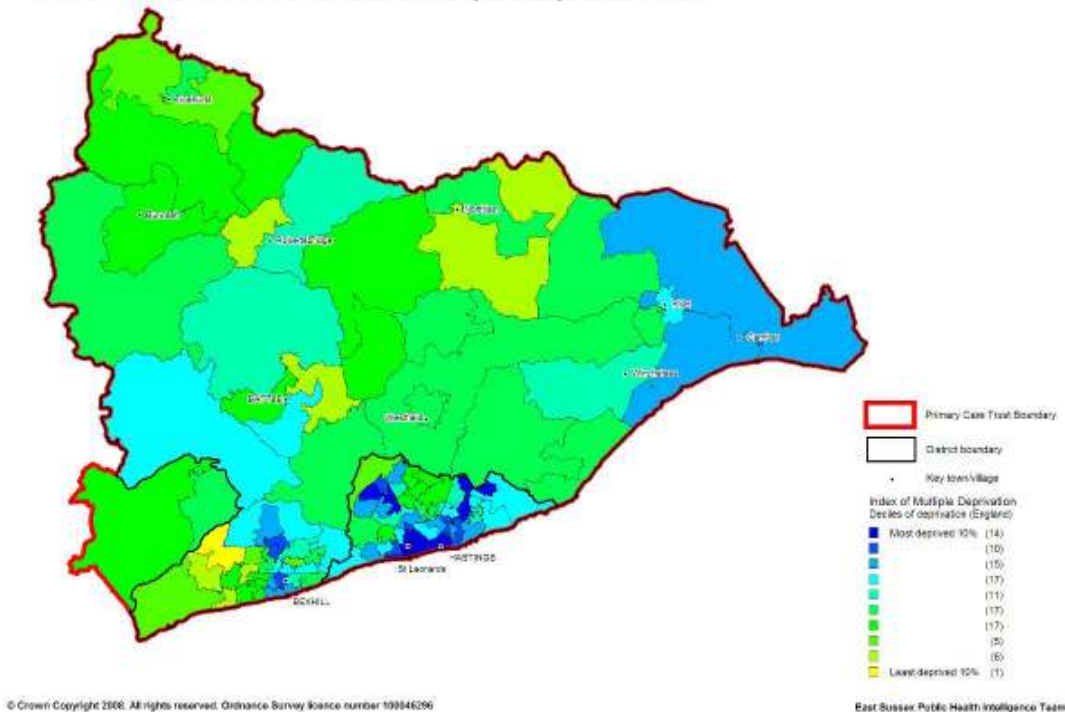


Deprivation

The Index of Multiple Deprivation 2007¹ identifies Hastings and Rother PCT as the 67th most deprived PCT out of the 152 PCTs in England. At a Local Authority level Rother is ranked as the 166th most deprived Local Authority out of 354 in England whilst Hastings is ranked at 31st. In fact Hastings is the most deprived Local Authority in the South East Region.

At a more local level, there are 14 Super Output Areas (SOAs)² that appear in the most deprived 10% of SOAs in England and a further ten in the most deprived 20%. These areas are concentrated in Hastings, St Leonards and Bexhill.

Index of Multiple Deprivation 2007 at Super Output Area level



¹ The Index of Multiple Deprivation 2007 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England.

<http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/>

² SOAs are a geography created by the Office for National Statistics to improve the reporting of small area statistics. Unlike electoral wards, SOAs are of consistent size across the country and will not be subjected to regular boundary change. They have a minimum population of 1,000 and an average of 1,500.

Appendix 3: The Peer Review Team

Staynton Brown

Assistant Director – Equality, Lambeth PCT

Michelle Cox

Head of Equality and Diversity – Commissioning, Liverpool PCT

Scott Durairaj

Thinking Partner, NHS Hastings and Rother (at the time of the review)

Teresa Edmans

Independent Health & Regeneration Consultant

Errol Francis

Senior Associate Coordinator, Race for Health

Madhun Foolchand

Senior Community Development Worker, Wolverhampton City PCT

Helen Hally

National Director, Race for Health

Fiona Wright

Associate Director of Public Health - Commissioning, NHS Haringey

Shared Intelligence - Race for Health Learning Programme Advisors

Sue Charteris

Learning Programme Adviser to Race for Health

Jacqueline Harrison

Learning Programme Adviser

Joanne Rycroft

Learning Programme Assistant

Appendix 4: NHS Hastings & Rother Participants

Dr Alex Abtahi

GP, Carisbrook Surgery

Habibah Anwar-Bhatti

Black and Minority Ethnic Development and Community Cohesion Officer

Anna Barnes

Primary Care Centre's Business Change Manager

Cllr Jeremy Birch

Non Executive Director

Gillian Brant

PA to Ivan Rudd

Jessica Britton

Deputy Director of Patient and Public Engagement and Corporate Affairs

Lisa Compton

Director of Patient and Public Engagement and Corporate Affairs

Jane Cook

CDW for BME Communities, Health Improvement Team

Rachel Day

Specialist Health Visitor, Children and Families Services

Kevin Dillistone

Health Promotion Advisor – Sexual Health/HIV and AIDs, Health Improvement Team

Isla Dowds

Patient & Public Engagement Planning Manager

Mebrak Ghebreweldi

South East Interpreting and Diversity Resource International

Rosemary Laughton

Practice Manager, Carisbrook Surgery

Cynthia Lyons

Deputy Director of Public Health

Hayley Martin

Health Trainer Coordinator, Health Improvement Team

Jed Murray

Community Development

Jenne Nicholson

Lifestyles Change Services Coordinator, Health Improvement Team

Alex Ntung

Community Cohesion Officer, East Sussex County Council

Amanda Rabbani

Health Trainer, Health Improvement Team

Ivan Rudd

Head of Health Improvement and Partnerships (at the time of the review)

Pat Scott

Commissioning Manager for PCT Provider Services

Shiva Serati

Hastings Intercultural Organisation

Jourdan Treverton

Equality and Diversity Coordinator

Mark Turczanski

Migrant Helpline and LINKs (commissioned services)

Becky Turner

Physical Activity and Health Specialist, Health Improvement Team

Sarah Valentine

Director of Commissioning and Primary Care

Lauren Brosson

Commissioning Manager

Appendix 5: 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.