Institute for Public Health Research & Policy
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Evaluating the "Race for Health"
Transformational Change Programme
in Central Manchester

**First report from the evaluation:
initial baseline findings and starting points for learning**

June 2004

1   Introduction

This is the first report of the team evaluating the "Race for Health" Transformational Change Programme in Central Manchester PCT. It is based on the team's presentation to the PCT's Access & Inclusion Group in April 2004. It summarises the team's baseline findings so far and highlights starting points for learning.

The team started work in mid-February 2004. In the first two months, we explored two particular areas: perspectives of PCT staff (predominantly managers as well as non-executive officers) and LAG members, and the sources of data about the black and minority ethnic (BME) populations of Central Manchester and their use of health services.

We begin the report with some background – on the Transformational Change Programme (TCP), on Central Manchester PCT's role in it, and on this evaluation.

We then report on topics we were asked to explore - workforce issues, and the state of BME data. Next (Section 6) we discuss 'opportunities and barriers' in relation to the TCP, as perceived by our interviewees.

We continue the report (Section 7) by outlining the next steps in the evaluation. The report's final section gives our recommendations from the work we have done so far. Appendix I lists current BME initiatives funded by the PCT, and Appendix 2 has information about the evaluation team. All documents referred to in this report are listed in the "References" section.

The team is very grateful to the many people, in the PCT and other local agencies, who have helped our work in many ways – being interviewed, finding documents, analysing data, arranging meetings, providing information, discussing our emerging findings.

2   Background

2.1   The Transformational Change Programme (TCP)

The TCP is a national initiative about transformational change in primary care, funded by the Department of Health (DoH). The "Race and Health" strand of the TCP originated from the DoH's Equality Strategy Group in 2002. Its aims were to "pioneer and model inclusive ways of partnership working with BME communities; improve services; create greater diversity in the NHS workforce".

This strand of the programme has now been renamed "Race for Health". It aims to support about 12-15 PCTs over a 3-year period (from 2003) in making radical improvements in the health and health service experience of BME communities. These PCTs are also expected to have a lead role locally, regionally and nationally in promoting these improvements more widely. One of the programme's main methods is sharing learning.

"Race for Health" is jointly sponsored by the DoH Equality Strategy Group, NatPaCT (National Primary and Care Trust Development Programme) and Central Manchester PCT. NatPaCT provides an important means of shared learning, by arranging and facilitating action learning sets.

Central Manchester PCT is the lead PCT. It manages the "Race for Health" funding nationally and hosts the project manager and administrator. The chair of the PCT represents participating PCTs on the programme's management board (Milnes 2004)

"Race for Health" is one of a number of current DoH initiatives on improving NHS services and opportunities for BME communities. (Examples are "Positively Diverse" and "Equalities and diversity" from the Human Resources directorate; "Delivering race equality: a framework for action" commissioned from the National Institute of Mental Health for England; "Leadership and race equality in the NHS" from the NHS chief executive.)

2.2   Reasons for Central Manchester PCT's involvement in "Race for Health"

- Central Manchester's population is very diverse. Drawing on the 2001 Census, the PCT's Health Needs Assessment document (2003) states:

> "The PCT covers an ethnically diverse area with around 31% of the population coming from a non-white ethnic group, compared with a City average of 19%. In both Longsight and Moss Side over 50% of the population is from a non-white ethnic group. The largest ethnic groups are Pakistani, making up around 10% of the population of the PCT, Black Caribbean (5%) and Black African (3%). In addition, 17% of the population was born outside of the UK or other EU countries."

BME communities are not distributed evenly across Central Manchester. For example (according to the 2001 Census), Pakistani residents are found particularly in Longsight, Whalley Range and Levenshulme, Bangladeshi people in Longsight and Rusholme, "Black Caribbean" and "Black African" (as the Census data categorises them) people in Moss Side, Hulme and Ardwick, and Chinese people in Ardwick, Hulme and Rusholme (Manchester City Council

Planning Studies Group 2002). Irish people are particularly likely to live in Levenshulme, Gorton South and Fallowfield (Manchester Joint Health Unit 2004).

- The PCT leadership had already shown commitment to responding to its BME population, and a number of initiatives were underway.

One of the PCT's early papers about "Race for Health" said:
> "In recognition of the diverse needs of the local population in Central Manchester, we are committed to demonstrating that the PCT is an inclusive organization. The PCT will be using the Transformational Change Programme as the vehicle to facilitate changes that will be necessary, so that services are accessible, can respond appropriately and sensitively to the needs of the local population." (Webster)

- There was already good practice in Central Manchester PCT to build on.

2.3 The evaluation – our approach
The evaluation team has a particular approach to evaluation. In our view, to use evaluation simply to judge success or failure is to miss a great opportunity. Evaluation can greatly strengthen initiatives. It should be a powerful tool for learning, improvement and even change. It is likely to be most powerful when owned by its participants: the stakeholders in what is being evaluated, the commissioners of the evaluation and the evaluators themselves.

Our approach to the evaluation, therefore, is:
- To develop ownership among participants;
- To encourage evaluative work as part of the TCP itself;
- To ensure that the views and experiences of local BME communities in relation to NHS services and employment are heard;
- To maximise the usefulness of the evaluation and maximise, as far as we can, the likelihood of the evaluation findings being used.
- To help to build evaluation capability (where desired) in the PCT and LAGs.

2.4 What are we evaluating
We were asked to evaluate the Transformational Change Programme in Central Manchester. But when we started to ask PCT staff what they thought about it, we found a confusing picture about what that is.

Some people had never heard of the TCP. Some thought it was all work on Access & Inclusion in the PCT (which would include issues of disability, for example, as well as ethnic and cultural diversity). Some thought it was the work listed in the Action Plan drawn up for the Access & Inclusion Group.

Our working focus so far has been broadly Access & Inclusion, with a focus on the PCT and local BME communities, looking at workforce, services and data. Some participants in the evaluation feel that workforce issues are being tackled as part of other DoH programmes and initiatives, and that the 'transformational' focus should be on services.

In the near future, what is being evaluated will need to be clarified, as part of the development of an agreed framework for the evaluation (see Section 7 below).

2.5   Our methods so far
The sources for the data we draw on in this report have been:
Interviews (individual and group), to gather perspectives and information;
Examination of quantitative data (and some analysis);
Looking at documents (PCT and national).

2.6   The baseline
What is it?
The brief for the evaluation of the TCP required an "initial baseline assessment" reporting in April 2004. But we found it hard to know what to look at for the baseline when what is being evaluated is not yet decided.

This report is part of that baseline assessment, but there is work done by others that should be included as well. For example,
* Claudette Webster's monitoring and audit work as listed in the Action Plan;
* Claudette Webster has used the Audit Commission's self-assessment tool "Towards race equality" (Audit Commission 2003) with a variety of groups within the PCT;
* Under the supervision of Public Health an Equity Audit is in progress which includes collecting data on local residents' experiences of services. In addition, we would like to see the views and experiences of local BME communities coming through strongly in the baseline.

We are therefore taking a common sense approach. We suggest that the baseline assessment should consist of:
* our work now – on workforce issues and data
* other relevant work now
* more in-depth work with BME communities.

How can it be used?
* It can be useful, for communication (about the TCP, or about PCT priorities or activities), for providing an information picture, as well as being a baseline against which to assess progress (for example, with staff).

* It can bring together similar pieces of work.

* It helps to identify gaps, needs, duplications.

* It can also help to point towards an evaluation framework.

2.7   Questions to bear in mind
* What is the added value of the TCP for Central Manchester? Is the BME-focused element of Access & Inclusion work doing anything beyond what the PCT would do anyway?

* What is 'transformational' in this work?

3   Workforce Issues

Data

The quarterly report for October to December 2003 showed that 14.2% of PCT staff were from BME backgrounds, compared with 31% of the PCT's population.

"Improving Working Lives" (the workforce aspects of the NHS Plan) and the Race Relations (Amendment) Act 2000 have stimulated a range of initiatives and policies introduced by the PCT's personnel and training sections. These include improvements to data collection.

Quarterly reports of workforce data are produced for the PCT by Manchester NHS Agency. Up to now, they have been fairly limited. Ethnicity is recorded and there are a number of categories. But the quarterly reports show simply percentages of "white" and "non-white" staff. Grade by ethnic group could be included in the reports if desired, but it is not at the moment. Similarly, ethnic group of job applicants is not reported. There is not yet any system for recording promotions, so it is impossible to track career progression after training.

These data systems are now improving. Improved data collection should provide more specific and detailed information on workforce issues. Improved information could be used as a basis for transformational change and to monitor progress. Over the next few months, it would be advisable to use and monitor this information to ensure that the information collected is what is needed and accessible.

Desirable outcomes might include speed of production of data, how it is used and regular monitoring. More explicit suggestions of how these initiatives and policies could be used for transformational change or to change mindsets might be helpful.

Staff views from our interviews

Staff interviewed felt that the main workforce issue was widening recruitment. A manager felt widening entry was not in the hands of the PCT, as this was decided by universities. 'Associate Practitioners' were identified as a possible way of widening recruitment. Outreach initiatives to inform local people about job opportunities in the NHS were welcomed and people thought it would be good to have more of them. One person felt that they had had problems with career progression, whereas two did not.

CHI staff survey 2003

Between October and December 2003, the former Commission for Health Improvement (CHI) carried out a national NHS staff survey, with samples from all trusts (and health authorities). The survey collected staff views about working in their local NHS trust. The results were analysed nationally and by individual PCT (CHI 2003), and also broken down by gender and ethnicity. (The latter gives only the broad categories "white" and "non-white", probably because the sample sizes were not big enough to support more precise categories.)

The Central Manchester PCT results are based on 379 'white' and 42 'non-white' respondents. They show that 'non-white' and 'white' staff have work experiences that are similar in many aspects, but on some aspects they do differ particularly. For example, 'non-white' staff were

more likely than 'white' staff to have had appraisals, personal development plans and health and safety training in the previous 12 months (68/54%, 76/62% and 43/37% respectively). But they were less likely to have had other training (82/90%). Although more of them were working extra hours (78/76%), they were less likely to be doing that because of the demands of the job (65/72%), a possible reflection of their level of seniority.

Staff in the survey also rated aspects of their experience working for Central Manchester PCT. Again, many of these were very similar in the two groupings, but some were not. (Ratings were from a low of 1 to a maximum of 5.) 'White' staff gave higher ratings to "fairness and effectiveness of incident reporting procedures" (4.8 compared with 4.2 by 'non-white' staff) and to their "perceptions of effective action from employer towards violence and harassment" (4.9 compared with 4.6). 'Non-white' staff were less likely to feel under pressure from work (3.1 compared with 3.4 for 'white' staff) and they were more likely to be thinking about leaving (3.0 compared with 2.6).

This was the first time such a national staff survey had been done, and it was intended to be an annual survey. If so, the data could be used in later stages of this evaluation. Local data could also be used to measure progress of some aspects against this baseline. For example, the improving local personnel information systems could be used to show whether training (as well as appraisals and personal development plans) was becoming more equitably available.

4   Training

4.1   Organisation of staff training

Staff have access to training co-ordinated by a range of agencies including the PCT's Education and Training Officer, the Manchester NHS Agency, the public health development service, the LEA and other agencies. There is no currently no central co-ordination.

One aspect of the PCT's Access and Inclusion work is training. Training can be relevant to the Transformational Change Programme in two ways:

- To increase capacity of staff to work in diverse communities

How does it compare to other ways of learning?
Long term impact of the training - does it make a difference?

- To provide opportunities which may enhance career progression

4.2   Information about staff training

Manchester NHS Agency have a database recording courses that they run. Information requested from course participants includes place of work, job category, discipline, ethnic group, but this is not always given. From 1 April 2004, nomination forms with missing information (for example on ethnic group) will be returned for completion before registration can be completed.

IT courses are recorded separately, as are public health development (health promotion) courses.

Staff may also attend external courses (eg on using the translation and interpreting services) run by the Local Authority. From 1 April 2004 all training attended by PCT staff will be recorded on the Integrated Personnel System (IPS) and on each person's Personal Development Plan (PDP).

4.3   Evaluation of staff training

At present, evaluation focuses on what people thought of the training, not what people are doing with it. No systematic follow-up information is recorded about how people are using training. The Education and Training Officer is interested in including this in the evaluation of training.

The existing information systems make it difficult to say exactly what training staff are accessing, but this should be addressed by the new system. (At the moment we just have information on the Human Resources training database.)

4.4   Training to increase capacity of staff to work in diverse communities

A strategic objective for the Access and Inclusion Action Plan was to incorporate Equality and Diversity Awareness Training into organisational training for all staff. This was to include
- induction training
- a programme of Equality and Diversity Training,
- a specific programme for Managers within the organisation linked to the PDP/Appraisal
- devising a monitoring system to evaluate the impact of Equality and Diversity training.

A component of the induction training has been established and run. Diversity Awareness training is offered by the Training Department, and 16 places per month are available. Participants are self-selected.

4.4   Views on this training

The training sessions are currently evaluated by means of an end-of-session feedback form. These evaluations are generally positive, but in our interviews a variety of views were expressed.

One member of staff (who had been and was committed to the issues) felt it should be compulsory. She said her manager had said she was too busy to go and she did not think her colleagues had been.

Another said that while diversity training helped in "looking at where my prejudices are", it wasn't so good on race – it needed to focus on particular issues of black communities and their experiences. "We need to hear everyday experiences." This person doubted that the Softfire course "is what we need or is doing what we need it to do. Bit wet, no bite, too soft, not challenging enough." This person also felt that a white training agency might not be appropriate.

Another interviewee felt it was hard to retain information from cultural awareness training but that talking with interpreters about cultural issues can be very useful.

One interviewee felt strongly that cultural awareness training should not be promoted as it can re-enforce professionals' sense of expertise that they know what is right for specific groups. (This person had no objection to people exploring or developing an understanding of cultures in general.)

4.5 Making this training more effective

The PCT's education and training officer plans to do a review of this training programme. She is interested in collaboration with the evaluation team to do this.

A number of interviewees identified ways, other than training, of increasing the capacity of staff to work in diverse communities. These included: learning from link workers, secondments to voluntary organisations and generally spending time with people from other cultures.

Cover is needed to enable staff to attend training (one person cancelled 3 times before making the Diversity training), and transport for staff who do not use cars.

4.6 Other relevant training

A sickle cell training workshop offered in September 2003 was attended by 14 nurses and admin and clerical staff from a range of health centres.

Manchester Public Health Development Service offers 5 courses which are specifically relevant to BME issues, three focusing on mental health issues. Only one of these courses ran this year: 'Mental health in multi-ethnic Manchester'. Four people attended from Central Manchester, none of whom were employed by Central PCT. Five people from Central Manchester (one of whom was an employee of the PCT) applied for 'Multi-ethnic Manchester', but this course did not run.

One interviewee mentioned that some training was being planned on working with asylum seekers.

4.7 Training and career progression

The PCT's Education and Training Strategy (June 2003) focuses on the following relevant topics:
The importance of education and training to career progression
Involving local people and skilling them up to meet human resources needs

In the strategy, there is nothing specific about access, inclusion, diversity, race, BME or reducing health inequalities, although there is an aim and objective about user involvement.

There is as yet no data relating to career progression, though there is interest in developing a method of monitoring the relationship between access to training and career progression. PDPs would appear to be fairly central here but no data is currently collected from these.

5 The data baseline - what data exists?

5.1 Method

This section draws on
• interviews with information providers (who were all very helpful, forthcoming and interested in our enquiries)
• examination (and some analysis) of routinely available data

Two questions in particular were pursued:

- What data currently exists about Central Manchester's BME population and communities?
- Looking at service datasets available to the PCT, in which of them is ethnicity currently recorded, and how? What are the problems and possibilities?

5.3   Sources of information identified so far on local BME populations

Data	Available from	Contents
2001 Census	Manchester Joint Health Unit	Range of information on local population (individuals & households) including demographic, ethnicity, religion, self-reported health, education, employment, housing, etc. Levels available: PCT, ward and smaller areas. (May be some under-counting in new housing areas.)
2001 Census Fact Sheet	Manchester Joint Health Unit	Summary of census information for each Manchester PCT. Broad ethnic groupings.
Key Facts series (drawing on 2001 Census data)	Planning Studies Group, Manchester City Council	No. 4 – Ethnic groups in Manchester (ward level) No. 5 – Ethnicity and age in Manchester (ward level)
Neighbourhood Statistics	http://neighbourhood. statistics.gov.uk	Available at postcode level drawing from Census and other data. Range of information on population (demography, ethnicity, religion, health, caring, education, employment), housing and crime.
CHI Patients Survey for Central Manchester local health services 2003	http://www.chi.gov.uk/ eng/surveys/nps2003/ pct_reports/ pct_5CL.pdf	National survey for each PCT, covering aspects of access, quality of care, information and choice. Low response in Central Manchester but sample is representative. BME responses not analysed separately (but are highlighted at national level).
Central Manchester PCT Health Needs Assessment (Oct 2003)	Public Health, Central Manchester PCT	Brings together a range of information at PCT level (demographic, homelessness, mortality, morbidity, drug treatment, child protection, hospital activity, screening, local views). Ethnicity available only in homelessness data.
LAG Health Needs Assessments (Sept 2003)	PCT Community Health Development workers	Participatory appraisal work with communities in Central Manchester, focusing specifically on provision of primary and community healthcare services. To be updated in 2004. Small number of BME views.
Equity audit – "Access to local health services" (in progress)	Khalid Akram, Public Health, Central Manchester PCT	Questionnaire including experience/views on access to GP and other primary care services, interpreting/translation, secondary care, health promotion, health information. Ethnicity included.

5.2 Service use data

The service datasets identified were:

Dataset	Available from	Contents	Ethnic recording
Community Activity System (CAS)	Manchester NHS Shared Services Agency (Carol Webster, Gateway House)	16 services including nursing, therapy, and some hospital-based (such as podiatry, speech and language, dental)	Yes, but often problems with collecting so incomplete and inaccurate. Own coding system
Commissioning Data Set (CDS)	Manchester NHS Agency (Jon Lawton, Gateway House) And from PCT (Carolyn Hurst). NHS Agency supplies data from this for Local Delivery Plan (monitoring of PCT performance by SHA) eg number of discharges, re-admissions.	Acute services – outpatient, inpatient, maternity.	Yes, but problems with collecting (especially in emergency) so large 'unstated' category. Improving. Coding system compatible with Census.
Cancer Registration Dataset 4.0	NW Cancer Registry, Christie Hospital (Kathryn Chamberlain)	Diagnosis, treatment, death (Latest data is for 2002.)	No, only birthplace. 'Ethnic category' introduced from 1 April 2004 but data coding 1 year behind. New coding will be similar to Census.
Child Health System	Manchester NHS Agency (Jenny Scott, Mauldeth House) Routine reports to nurse managers and public health. Used by Sure Start.	Covers all children in Manchester, from birth to 16 (sometimes 19). Birth, immunisations, assessments, current GP and Health Visitor, special needs, vulnerable children. Links to some clinical systems too.	Yes, complete ethnic recording since Oct 2002. Coding system quite similar to Census.
Exeter system	Manchester NHS Agency (Carol Smith, Gateway House)	GP registration and screening data.	No.
Mental health minimum dataset	Manchester Mental Health & Social Care	'Spells of care' – clinical problems,	Yes – quality unknown.

	Trust (Debra Lennard) Data goes directly from provider to Dept of Health.	treatment, social care, outcomes.	

5.4   Recording of ethnicity

Below we summarise our findings about the recording of ethnicity in currently available data about Central Manchester residents. We suggest the best examples, look at problems and then at likely future trends.

5.4.1 Good sources now

Two data sources offer what is currently the most complete recording of ethnicity:

- *The 2001 Census*
  The Census offers broad groupings (such as Asian) and more specific groups (such as Pakistani, Bangladeshi). It is not flexible enough to show newly emerging refugee communities. For example, it does not distinguish between different black African communities (such as Somali, or Congolese) which are all included under "Black African"; and Kosovans disappear into "White Other".

  Census data by ethnic group is available for wards, and (as percentages) for postcodes. Although there is probably some under-counting in parts of Central Manchester (especially in new housing areas which may not have been included in the Census), the proportions of the various ethnic groups are probably reliable.

  The Joint Health Unit (based at Manchester City Council) is the PCT's main source for analysis of Census data and offers particular expertise in its use in health.

- *The Manchester Child Health System*
  Midwives in Manchester record all births electronically on this system, and since October 2002 they have included ethnicity. There are two particular strengths to this dataset. One is that the categories used are similar to the Census but also offer the flexibility for including new groups (for example, Somali and Middle Eastern are among the current categories). The other is that the percentage of unknowns is very small – about 4% (108 out of 2464 births notified between October 2002 and March 2004).

  Routine analyses by ethnicity are requested by (and provided to) the Sure Start programme for Moss Side, Rusholme and Fallowfield.

5.4.2 Problems with provider data

- Different coding systems – a variety of ethnicity coding systems are in use, introduced at various times. Some allow for specific new refugee communities (such as Kosovans), others don't (categorising them as 'White other'). Some systems closely match models used widely in the public sector, such as for the Census or local authority 'best value' data collection. Others bear little relation to these. Even so, it is possible to make compatible categories between the systems, but only for very broad groupings (such as Black African).

- Patchy recording – all systems have large numbers of 'unknown' or 'unstated' ethnic group entries. Reasons offered for this included collection problems (such as in Accident & Emergency) or staff embarrassment which some interviewees related to lack of training. The only system that claims 100% recording of ethnicity at present is the Child Health System.

- No coding at all – this applies to some of the older paper-based systems, but also the pre-2004 Cancer Registry data and the Exeter system (general practice registration and screening). Both of these systems were developed in an earlier era. The Cancer Registry record includes 'country of birth' but this is often not filled in.

5.4.3 Likely future trends in NHS recording of ethnicity

The national NHS IT Programme is gradually transforming NHS data and information systems. Now that each patient has a unique ID number (for the first time in the history of the NHS), a central feature of this transformation is the introduction of a core electronic record – the 'patient data spine' - for each patient. The exact contents of the record are still under discussion, but it will have demographic information and will include ethnicity, probably categorised similarly to the 2001 Census. All NHS clinical systems will eventually link to the spine. The 'patient data spine' is being introduced from June 2004, but is not expected to be in use everywhere until 2010.

So the trend is towards better recording, compatible coding systems and increased linking, all of which (as intended) should make for health data which could be much more powerful in identifying need and tracking and reviewing change. But it is unlikely that this national trend will have major local effects during the Transformational Change Programme (that is, over the next two years), although the Commissioning Data Set (acute trust services) may be linked to the 'patient data spine' by June 2005.

[Information for the above paragraph was drawn from various sources: interviews with data providers, recent articles in the specialised press, material on websites of agencies such as NHS Information Authority, Department of Health, Office of National Statistics.]

5.5   Ethnic monitoring of services

As far as we have been able to discover, no ethnic monitoring is carried out by or on behalf of the PCT at present. All data providers reported that there had been no requests from Central Manchester PCT for any analyses by ethnicity.

Despite the current problems with the data, some analysis is possible with some datasets (see table above). Most of those supplying data to the PCT expressed interest in pursuing this. It might be encouraging to providers to see this data being used. Interviewees suggested that some improvement in the data would be possible by ensuring that training in asking about ethnicity is provided to relevant staff in service provider organisations.

5.6   What's known so far about BME views of services

As part of our baseline work, we are exploring what is known of the views of Central Manchester's BME communities about local health services. There are two particular pieces of work we have looked at so far.

Local Area Group health needs assessments

On behalf of the Local Area Groups (LAGs), the PCT's community health development workers conducted "health needs assessments" (HNAs) in the autumn of 2003. Their approach was participatory, drawing on and involving workers and residents in the local areas, and using several different (non-survey) methods. They were able to obtain BME views in many areas. These HNAs are being updated and the results will be available in the summer of 2004.

Looking across all the local areas, some common themes can be seen which point to particular needs being expressed by BME communities. These were:
- language needs, such as interpreting and translation;

- cultural/linguistic specific needs - counselling and dieticians were mentioned, and the need for female GPs was highlighted;
- information on services (in English and in translation)

National patient survey 2003
The Commission for Health Improvement (CHI) carries out an annual national survey of NHS patients. The survey is actually 4 surveys – sampling inpatients, outpatients, accident & emergency patients and users of primary care services. These surveys are designed to contribute to the star ratings for trusts, and the subject-matter focuses particularly on access and waiting, quality of care, information, relationships with professionals, and the physical environment of the service.

Data from each survey is available for each trust, so there is data for Central Manchester PCT on users of its primary care services.
This sample (273 respondents) is ethnically representative of the area, but the BME response is too small (31% or 85 people) to be validly broken down into any subgroups.

CHI has published a report of the data for England as a whole in which analyses by ethnicity are included (CHI 2004). Over England as a whole, South Asian groups - especially Bangladeshi patients - report the poorest experience of health services. (There is no reason so far to assume that Central Manchester is greatly different.) The report "highlights the need to improve the quality of services provided to ... people of minority ethnic origin" and says "Trusts also need to improve the coding of self reported ethnic origin in patient records".

5.7   Recommendations on using and improving data
a) The baseline is that there is no ethnic monitoring. It could be 'transformational' to aim at routine ethnic monitoring (that is, provision of data and regular review of it by the PCT) for one or more services by a certain date.
b) There should be links between the LAG HNAs and the TCP action plan;
c) The PCT should review its community involvement strategy to ensure that BME communities are fully included in its methods of listening, consultation and service development.

6   Opportunities and Barriers

6.1   Where are we now

The Audit Commission's self-assessment tool
In addition to our interviews, data on 'where are we now' comes from the sessions conducted by Claudette Webster (the associate director for access and inclusion) using the Audit Commission's organisational self-asssessment tool "Towards Race Equality". A range of staff in these sessions assessed the PCT on the tool's dimensions of action. The tool's 5-point rating scale goes from "Resisting" to "Achieving". All sessions resulted in the rating "Starting", meaning that there were some signs of moving to racial equality but little sign yet of permanent change.

Our interview data
Among our interviewees, there was a general feeling that there were a number of projects provided by the NHS and voluntary agencies for BME communities and these have built up in a fragmented way. Core service developments (eg elderly and sexual health services) often

exclude the needs of BME's. There was a feeling that this leads to services 'problematising' BME communities because services are designed for different communities and then BME's don't fit into the mould that has been created for the services.

Many people said that the TCP is happening at the top and doesn't come down to the local areas. For example, staff felt there was a lack of information in local areas about entitlements concerning the Race Relations Act. Staff also reported increasingly working with other agencies such as churches to address needs (for example, to provide advice for asylum seekers).

6.2 The Transformational Change Programme (TCP) – what is it supposed to achieve?

Most people felt that to embrace the needs of a diverse population, a change in the culture of the organisation was required. This would change the situation of services for BME communities from 'add on' to 'core work'. This will require:
- A structural change in the PCT,
- a more in-depth understanding of need,
- changes in the way services are commissioned and from whom,
- development of staff and voluntary sector capacity to respond to needs,
- changes in the mindset of managers - including directors - that these issues are core business
- encouraging PCT staff to ask questions about other people's culture/ needs
- changes in human resources policy and practice

This would lead to a different, more equal, relationship between the PCT and the communities it serves, described by one interviewee as:

> *"We need to get the community into the organisation, working with us to provide and deliver services for the population at large."*

This view broadly sees the service as the focus of the transformation, largely at an organisational level.

A minority view saw the main issue as the population's access to services and their understanding of entitlement to a set of services that exist to help them. This would involve identifying ways for the PCT to work more effectively with individual communities, and some specific service provision. With this view, there was more of a sense of the need for communities to transform or adapt to what the service currently provides, and that work needed to be done with each community rather than with services, professions or areas such as Human Resources and Commissioning.

One participant pointed out that Race and Health issues had been a concern for the last 20 years but "*we are still at square 1.*" In other words, these are difficult issues to address. The participant felt they could be talked about but it was difficult to say what was needed on paper, which may be part of the problem of addressing these things.

6.3 Opportunities presented by the TCP

Interviewees felt that the TCP provided a number of opportunities for the PCT and they identified a number of strengths and strategies for making it work. These included:

6.3.1 General opportunities

- to see where we are up to
- to address lack of direction
- do some in depth work.

   "'What inequalities do different populations face in terms of our services?"

- biggest impact would be via commissioning
- to address problems of recruitment and retention
- make changes to health outcomes and experience in Manchester

While the majority of people interviewed saw the opportunities in terms of the PCT, there was a minority view that saw external opportunities as well. This was in terms of partnership work across the city, with the local voluntary sector, the local authority, PCTs and Acute Trusts. In addition there was the potential to influence things regionally and nationally,

   "to show people how to do it."

6.3.2 Capacity, infrastructure and commitment

Participants felt there were:

- a number of good projects, initiatives and good practice by individual members and groups of staff
- interested staff and champions for addressing issues of access for people from BME issues
- staff who are very skilled at challenging racism
- commitment of Chair and Chief Executive
- Employment project in acute trusts (to learn from)
- Good infrastructure for community development (Health and Well-being teams, LAGs)

6.4   Barriers and potential barriers to progress

6.4.1 Definition of BME
There was no consensus about who is from black and minority ethnic groups. Opinions varied from all people who are black to anyone who thinks they are from a minority group, which included all white people in a predominantly black neighbourhood.

The most common view was that it should include all black people and all refugees and asylum seekers as the latter experienced similar problems whether or not they are black. There was an opinion that groups who had come more recently to the UK had most problems accessing services and fewer support networks, and that there is evidence that some long established white groups experienced particular problems with services (for example Irish people in relation to mental health services).

There was a strongly held view that it was crucial to focus the project strongly on the needs of black people and have an understanding of why this is important. It is important to recognise the marginalisation of BME people, the impact on their health, access to services and especially to appropriate ones.

6.4.2 Why are BME issues a priority?
One barrier identified was the lack of acceptance by some key players that a focus on BME issues rather than poverty as a whole was appropriate. This was seen by a participant to indicate lack of understanding of the relationship between poverty and race as it impacts on the PCT's population.

6.4.3 Talking about BME issues
Some interviewees felt that the fear white people have of getting things wrong when talking about race is paralysing. Some professionals/managers feel that they should know what people from BME groups need and find it difficult to say that they do not know.

Recommendation
Changing the mindset demands more dialogue. White people need to feel comfortable about talking about race, and to ask questions and not base action on assumptions.

6.4.4 General depth of understanding of BME issues
While most interviewees thought there was a general understanding of BME issues, they felt it was difficult to develop a more in-depth understanding. They felt there is a lack of strategy or coherence in approach, by the PCT as a whole. This was of particular concern in terms of ensuring that mainstream services would be appropriate and accessible to BME groups or that BME people would have access to jobs and career progression.

This requires a deeper understanding of the issues and how to address them. In practical terms, there was concern about whether long term needs were being addressed by people with the power to identify solutions. For example what would happen to translating and interpreting services when funding runs out in twelve months?

> "We are scratching the surface. The service is pump primed by NRF. There is some good work. Some serious thought needs to be put into it soon by the leads of our organisation. There is only a year's funding left, it's a massive issue with more refugees and asylum seekers coming in."

The need for in-depth understanding is well illustrated in relation to the linkworker service. Two staff were very positive about the service, whereas one felt it was deteriorating. Their experiences relate to redistribution of the service that is currently going on. Issues for staff about language include:

- A member of staff who is bilingual is not paid as bilingual worker but for clinical skills. Objects to working in languages other than English
- Would be good to have more mainstream literature on other languages, eg appointment cards, family planning literature
- It is difficult for non-English speakers to understand how to use GP services, eg registration, appointments and what people can expect from a service
- Talking with interpreters is very useful; they are a good resource on cultural issues

- It is hard to sound 'gentle' if there is no shared language
- Lack of interpreters leads to less job satisfaction – perhaps a staff retention issue
- Lack of interpreters leads to poor use of services – do not attends etc

Other issues which were raised included:

- What is the PCT doing to hear black staff?
- A need for more reflective practice, eg where services only have leaflets in English in areas with a high BME population and a high number of DNA's, does anyone ask why?

6.4.5 Impact of TCP so far

Some expressed concern that the TCP is already 12 months old and that there had been little visible impact. A number of useful points emerged in relation to this:

- Lack of shared vision. Some people were concerned about this. One person thought it urgent and hoped that the work the evaluation team propose to do with the Access and Inclusion group in order to develop an evaluation framework might help develop this. Barriers to developing a vision identified, included external factors, for example goal posts have changed which the PCT has little control over.
- Lack of impact could affect the credibility of the project within the PCT; some early wins were important
- Disappointment was expressed that the initial focus on commissioning might have been lost. There was a fear that the lack of vision might lead to loss of direction and doing work that should be being done anyway.

Problems identified that need to be overcome in terms of impact included:
Ownership
- The initiative is seen as top down, led by the Chair and Chief Executive; not the Directors. There is a lack of wider ownership
- It is very dependent on 'champions'
- The issues are seen to be of concern almost exclusively to BME people
- If staff have been told about it, recall is low.

Communication
Staff interviewed felt that communication was seen as poor within the PCT in general and in particular concerning the project. While people steering the project may feel they have informed staff, the message was not reaching staff.

E-mail was not considered an effective way of communicating. It was suggested that brief information should be made available about what the project is trying to achieve, how and how people could be involved.

Infrastructure and capacity issues
A number of issues were raised about infrastructure and capacity that may be barriers to transformational change. These were:

1) capacity of the organisation as a whole in relation to addressing BME issues

- the number of people in areas such as human resources, commissioning. This raised the question about the viability of a top down model (eg to commissioning). Would it be

more viable for the project leader to work with service managers and their staff and drive changes in commissioning in a service led way?

- Unfilled vacancies (especially shortages of health visitors) may mean staff do not have time to address these issues
- However there are also concerns about whether it is easy enough for interested staff to get involved with the transformational change programme. One example of this was that initially the plan had been for the Diversity training to be run as a 'training the trainers' course and, by 2005, to skill up 60 staff as trainers. This did not get off the ground due to lack of take up. Staff asked about this did not remember this intiative.
- Lack of involvement of the staff side in the TCP - an under-utilised resource
- Where staff are involved, they do not always find their contribution valued. Problems such as
    - Difficulty in finding out when meetings are
    - Turning up, having arranged cover, to find that meetings do not happen - this deters further involvement
    - Lack of information on what has happened to initiatives (eg Race Relations Amendment Act) leads to feeling that things are started and not completed

2) transforming relationships with the voluntary sector
- "*Historically we fund people and keep the funding static. We only get concerned when there is a problem.* "
- Develop equal partnership in commissioning and supporting; the Trust has money, they have the links, knowledge
- Ensure that voluntary organisations are meeting or are able to meet their contractual obligations, improve monitoring
- Voluntary sector need longer-term funding
- Develop capacity in the voluntary sector. Potential to involve organisations such as Progress Trust, Race and Health Forum.
- Example highlighted where a member of staff of a local BME voluntary organisation has been trained by the PCT to do cervical smears

3) workforce potential
- Managers don't always support staff to reach their potential
- BME staff do not always recognise their own potential. They do not often choose to go on leadership courses because they do not expect to get the jobs. They need encouragement

6.5   Who can make a difference?

The most important people to get on board were Directors, senior and middle managers. It was felt that people in these positions felt that they knew or should know how things should be done in general and for BME communities in particular. They could be resistant to new ways of doing things. This can be a blockage to 'transformation' or lead to different ideas about what needs transforming as discussed earlier.

The lack of ownership is coupled in some situations with scepticism about what the project will achieve. In the case of sceptical people who have influence in the organisation, they do perhaps need to be asked what help they can give to make the programme work.

6.6   Reducing the barriers

One of the strengths of the PCT is that it was clear to us just from our interviews that the capacity to address the barriers exists within the organisation. Some of the interviewees' suggestions are included below:

- There is a need to capture what there is the resource to do and to ensure that is well utilised
- Potential for nurturing capacity and commitment
- Senior officers who are not committed will change if they get something out of it (eg performance-related pay)
- Develop capacity of service heads and managers (they do not do the depth work because of lack of capacity and/or drive)
- There are staff at all levels who are committed, have skills and experience to offer and/or would like to develop these and who would like to participate more in the TCP. But they are not getting involved, or not as much as they would like to, because they are expected to do this on top of an already demanding workload. In order to maximise the skills, experience and commitment within the organisation, an initial transformation needed is how to make this part of manageable core work. TCP initiatives need to enable managers to encourage and free up staff to engage in TCP activities including training, evaluation, participation in meetings and initiatives.
- Once involved, ensure information about meetings is accurate and it is possible to access people to confirm arrangements. Staff need to be kept informed of developments

Ideas for how to do it included:
- diversity and induction training
- working with specific services and/or professions on mainstream, in-depth service delivery and/or employment initiatives appropriate and accessible to a diverse population
- focussing on staff spending time with BME groups – secondments to voluntary sector, success of Sylhet visit, go shopping to places like Longsight market
- More directive – *'why is irrelevant; the law says we should be doing this'*

A fear was expressed that the programme may result in more needs assessment with insufficient depth and more projects, things the PCT should be doing anyway. In terms of a constructive way forward it was suggested:

> *"You can't change mindsets without doing something practical. You can talk about strategies and plans … but people don't change their practice until you get into a specific area of work and pull that to pieces and unpick it. That's when you start challenging behaviours and attitudes – whether you are talking about someone doing commissioning or delivering services. That's why it's important to be specific about task. . . . It would be helpful to start prioritising 2-3 areas, and engage service area heads on that area of work. That needs to happen soon if we are going to make an impact."*

6.7   Ways of making a difference
Participants identified three levels of working: strategies and frameworks, learning through practice and project-based work. It was felt that work on transformational change had so far been strong on strategies and frameworks and there was a lot of project based work targeted to

BME communities in Manchester. Participants identified that one aspect of the transformation was a move from project based work to broad mainstream approaches.

A potential model was identified to enable learning through practice, which has been successfully used in a citywide employment initiative. It has involved NHS service managers and employment agencies in a practical solution-focused project. It has had visible results – enabling long term unemployed people to get jobs. Attitudes and practices have changed to enable this to happen. This model of enabling managers to change practice could be explored to develop the capacity and practice of managers and staff teams in a range of settings such as workforce, service delivery and commissioning.

6.8 Views on how the evaluation can help

We asked participants if they thought the evaluation could help, and if so how. They suggested that the evaluation could inform the TCP in the following ways:

- Consider whether BME services move from being ' add on' to core
- Case studies of things that have changed mindsets
- Reportbacks
- Suggestions of what the TCP could be doing
- Honest, critical friend, don't collude/ protect people
- The staff side want to see our report

7 Next steps in the evaluation

There are two strands to the work required to complete the baseline.

7.1 Digesting and collating existing information on BME communities' views of services.

The Black Health Agency has a considerable amount of material which we will be sifting through in the next 2-3 months, and we are searching for other local material. The team would also like to carry out some further work with BME communities as required. Ethical approval has been obtained from the Local Research Ethics Committee and the University of Salford Research Ethics Committee.

From this work we will produce a further (short) report, by October 2004.

7.2 Completing the evaluation framework

We began to develop the evaluation framework at a productive workshop with the Access & Inclusion Group in May 2004. They decided that we should further develop the framework by working with the managers leading on the sections of the Action Plan. This process will continue during the summer and should be completed in September 2004.

8   Recommendations

On the basis of our work so far, the evaluation team offers these recommendations to the PCT. [All appear in the preceding sections but are drawn together here for greater clarity.]

8.1   Workforce issues

Improved data collection from April 2004 should provide more specific and detailed information on workforce issues. This improved information could be used as a basis for transformational change and to monitor progress.

Use and monitoring of this over the next few months would be advisable to ensure that the information collected is what is needed and accessible.

8.2   Training

a) Issues emerged as to whether secondments to voluntary organisations and working with linkworkers are effective approaches to increase staff awareness and capacity to work in diverse communities.

Comparison of these different approaches would be a good area for research. The evaluation might work with staff to look at the impact of training.

b) Up until April 2004, information collected on access to training and impact of training on career progression was not available. Improved data collection should enable better information on this.

Use and monitoring of this over the next few months would be advisable to ensure that the information currently being collected is what is needed and is accessible.

8.3   Using and improving data

a) The baseline is that there is no ethnic monitoring. It could be 'transformational' to aim at routine ethnic monitoring (that is, provision of data to the PCT and regular review of it by the PCT) for one or more services by a certain date.

b) There should be links between the LAG HNAs and the TCP action plan;

c) The PCT should review its community involvement strategy to ensure that BME communities are fully included in its methods of listening, consultation and service development.

8.4   Taking opportunities and reducing barriers

Opportunities

* There are many people within the trust who are committed to BME issues and have developed good practice. In some areas there is strength in infrastructure (eg community development) whereas in other areas there is lack of infrastructure (eg commissioning). There is a need to capture existing resources and use them well by nurturing and developing capacity and commitment.

* There is a need to encourage BME staff to reach their potential and for managers to recognize their potential and encourage them.

* Relationships with the voluntary sector as well as BME communities also need to be transformed.

* The Transformational Change Programme needs greater focus and this should be on in-depth work.

* It is important that the programme includes visible action with results in the short term. This will help to increase understanding and confidence in the project which may in turn increase motivation for people to get and stay involved.

* There are several health projects in Central Manchester for BME communities. The TCP has made progress on developing strategies and frameworks. The gap is in involving managers in good practical in-depth work where they can learn through experience. A model was identified which could be tried out in a range of areas.

Barriers
* Fear of talking about race and getting it wrong is a barrier. 'Spending time' in a range of ways with people from other cultures to build understanding and develop open, honest questioning dialogue may be a way forward.

* No consensus existed about who are Black and Minority Ethnic Groups. Definitions varied from people who are black to anyone who thinks they are from a minority group, which included white people in a predominantly black neighbourhood.

* More clarity on what is transformational would be helpful.

9   References

Audit Commission (2004), *The Journey to Race Equality: delivering improved services to local communities*, accessed at http://www.audit-commission.gov.uk, then search on "Race"

Commission for Health Improvement (2003), *NHS national staff survey 2003*, Central Manchester PCT results, accessed at www.chi.gov.uk/eng/surveys/nss2003/pct.shtml#c

Commission for Health Improvement (2004), *Unpacking the patients' perspective: variations in NHS patient experiences in England*, accessed at www.chi.gov.uk/eng/surveys/4539_survey.pdf

Manchester City Council Planning Studies Group, *Keyfacts 4: Ethnic group of residents in Manchester 2001*, undated.

Manchester Joint Health Unit (2004), *The health of minority ethnic communities in Manchester: a summary of the current evidence,* forthcoming, likely to be available at http://www.manchester.gov.uk/health/jhu/intelligence/reports/index.htm where an earlier version can currently be accessed.

Milnes, P (2004) *Note for Salford University Evaluation Team*, Department of Health.

Webster C, 'Local Leadership', in Milnes P, *Transformational Change Programme: Race and Health*, Central Manchester PCT, undated.

Existing initiatives with and for BME communities
in Central Manchester funded by the PCT

[drawn from presentation by Associate Director for access & inclusion at the Access & Inclusion Group's meeting on 4 March 2004.]

Access
*Translation and Interpretation Service (joint with other Manchester PCTs)
*Quality Standards awards scheme (GP practices and information for patients)
*CHD access to cardiac rehabilitation facilitator (targeted to South Asian women)
*Chinese Health Information Centre
*Cancer – cervical cytology (targeting the South Asian community)
*Diabetes/CHD (working with Bangladeshi and Somali women)
*PMS (personal medical services) scheme for asylum seekers/refugees (joint with North Manchester PCT)

Service delivery
*Sure Start – Gorton/Gorton West/Ardwick, and Moss Side/Rusholme/Fallowfield)
*Sure Start asylum seeker/refugee project (especially Gorton)
*Cancer - Expert Patients
*Drug/alcohol (targeted around South Asian communities)
*Mental health – child and adolescent mental health services
*Diamond Project (Asian women and domestic violence, may possibly make links to eg cervical screening)

Commissioning
* Race and Health Forum
* Asian Older People Development
* Black Health Agency
* Afro Caribbean Care Group [older people]
* Chinese Health Information Centre

Public health
These initiatives aim to target poor health but also to have a beneficial effect on whole community

* Herbs and Spice – nutrition/food
* Alfa – physical activity, esp obesity – CHD, lifestyle.
These are linked, both are collaborative with community groups. They started as targeted at Afro-Caribbean, SE Asian and Irish communities, but now all communities.

* Smoking Cessation Project – especially South Asian people

* Health and Wellbeing Team project – especially community information and knowledge of health services

* Marim – refugee integration into Manchester – led by Social Services – now have Neighbourhood Renewal funding to employ a school nurse and health visitor to work specifically with refugees and asylum seekers.

Who are the evaluation team?

The evaluation team is based at the Institute for Public Health Research & Policy, University of Salford.

Dr Meg Allen, research fellow, has worked as a researcher in a variety of Manchester health and social care organisations, carrying out research into the needs of homeless people and the educational and social needs of homeless families. She has worked with refugees and asylum seekers in Central Manchester and has also carried out research with excluded groups such as drug users, street drinkers, and people experiencing mental health problems. As lead evaluator of two Salford Sure Start programmes in Salford, she currently works with a variety of projects as an evaluation facilitator, by assisting projects to design and carry out their own evaluations and helping them to disseminate their evaluation results. She is also a member of a Local Area Group (LAG) and is familiar with the LAGs' role and remit.

Mary Black, senior research fellow, has a long-standing interest in the relationship between research and policy, which she has explored in academic and policy settings through posts in the Equal Opportunities Commission, a district general hospital and Manchester and Salford Universities. Based at IPHRP since 1997, she has recently managed projects evaluating new initiatives in Salford and Manchester concerned with devolving decision-making about health to community groups (Real Lives, a HAZ Innovations project) and providing services for families with young children that are responsive to local needs (local evaluation of five Sure Start programmes in Salford). She is also part of a team providing research training and advice for NHS staff in the North West, and runs workshops on evaluation and on Research and Development Awareness for service users to enable them to take a more active role in planning and conducting research. Since 1999, she has been a non-executive director of Tameside and Glossop Acute Services NHS Trust.

Judith Emanuel, freelance consultant, has a background in health promotion, public health and primary health care in Manchester and Zambia. Over the last 10 years she has worked for Manchester and Salford Universities and in and with health, local authority and voluntary organisations across the city. Her primary interests are equity and health and participatory research and action especially with young people. She developed regional guidelines on services for disabled people with physical and sensory impairments, which actively involved BME disabled groups in Manchester. She has done participatory health needs assessment in areas with high BME populations in Oldham. As well as research and evaluation, she trains and facilitates groups at all levels on a range of strategic and developmental issues. She lives in Central Manchester and is a member of the Bloom (Central Manchester Healthy Living Network) core evaluation group. Running a Primary Health Care degree programme in Zambia helped her to develop her global understanding of racism and cultural issues and their impact on health.

Angela Young, senior research fellow, is a social researcher in public health who has increasingly specialised in evaluation. She draws on both qualitative and quantitative research methods (including analysis of a range of public health data). She has worked with the NHS and community organisations in Manchester and surrounding areas, and with health and local authorities across the region. Her recent projects have focused on: organisational effectiveness in tackling health inequalities, community involvement in health decision-making, and evaluation of (and in) Manchester, Salford & Trafford health action zone. She is a board member of what is now the Big Life Company, and has recently been appointed to one of the new Patient and

Public Involvement Forums. She is an active member of the UK Evaluation Society and was a founder of the North West Evaluation Network.

Team members' roles
Mary leads the team and manages the evaluation. Meg is leading the LAG aspects of this evaluation. Judith and Angela lead on the baseline stages of the evaluation and on the earlier (to March 2005) stages of the evaluation of the TCP action plan. They are responsible for ensuring that the views of service users are incorporated into the work. Angela leads on the development of the evaluation framework. The thinking and planning behind all our work on this evaluation is a product of all members of the team.