

race for health



a transformational change programme

Westminster PCT Peer Review

7th – 8th December, 2005

Outcome paper

Introduction

The Westminster PCT Peer Review took place on the 7th and 8th of December, 2005.

The visiting team of Peers included representatives from Bradford City, Camden, Ealing, Eastern Leicester, Lambeth and Wandsworth PCTs. They were drawn from all levels of their organisations, and included a Chair, Community Development workers, three staff at Head/Director level, and Equalities and Diversity Leads. The team also included the National Director of the Race for Health programme, a representative from the Department of Health and the learning programme coordinators, Shared Intelligence.

Over the course of the Review, the team heard a number of presentations from Westminster PCT's management, including its Chair, Chief Executive and Head of Commissioning. The team also had the chance to meet the manager of Westminster's BME Health Forum and speak to a range of PCT staff from different service areas (full lists of Peers and participants can be found in the appendices to this report). The Review consisted of an evening and a full day, with time set aside for the team to discuss and formulate its findings and briefly present these back to the host PCT.

This paper sets out in more detail the Peer team's findings and recommendations. However, it is drawn entirely from their discussions on the day, and as such will provide – much like the day itself – a set of 'informed reflections' of WPCT's work in the area considered, rather than detailed research or in-depth analysis.

Theme and key questions for the Review

The thematic focus for the Review consisted of two interlinked aspects:

1. The effectiveness of community engagement, with a specific focus on mental health services; and
2. How feedback from community engagement can inform commissioning strategies within the PCT, and support promotion of race equality through 'managing the market'.

Key questions considered by the team included:

- Has Westminster PCT recognised all of the issues emerging from the review of Black and minority ethnic (BME) mental health (*'Caught between Stigma and Inequality'*), and the subsequent community consultation?
- Is WPCT adequately engaging with its BME communities, and are these communities influencing the commissioning of mental health services in Westminster? How could this link be strengthened for all health services?
- How could WPCT use these findings to 'manage the market' better – i.e. through influencing service design and delivery by existing providers, and building the capacity of community and voluntary sector (CVS) providers?
- What gaps or barriers can be identified for further improvement?

SECTION ONE

Background and context

The City of Westminster

At the commencement of the Review, Westminster PCT's Director of Public Health, Margaret Guy, gave the Peer team an overview of the demographic makeup of the borough and the challenges facing the PCT. They emphasised that Westminster isn't merely the 'prosperous centre of government' that it is often perceived as – in fact it is the most polarised borough in the whole of England, and contains some of its most deprived wards. There are 120 'Super Output Areas' in Westminster, signifying areas of particular deprivation, with a third of these falling into the most deprived 20% in the country.

Ethnicity

Ethnically, it is hugely diverse; Black and minority ethnic people account for at least 27% of the population and around 40% of children, and the number of languages spoken is extremely high. There are some long established communities - particularly African Caribbean, Bangladeshi, Arabic and Chinese – as well as substantial newer communities from Eastern Europe, South America, and others. Many of Westminster's BME populations are concentrated in particular areas and neighbourhoods within the borough. However, the ethnic composition of the borough as a whole changes constantly, reflecting the very high mobility of Westminster's population and the constant influx of visitors.

Health inequalities

Margaret Guy's presentation starkly demonstrated the extent of the health inequalities that exist within the borough. Headlines included the following:

- There is a 16-year life expectancy gap between men living in the Church St ward and men living in Belgravia ward, and a 14-year gap between women in the same areas. This is the largest gap of its kind in England.
- Higher than average mortality rates mirror patterns of deprivation and concentrations of BME populations. There are clear lifestyle links between the incidence of coronary heart disease,

obesity and lung cancer and certain communities – e.g. diet and physical activity rates for Pakistani women, or smoking for Bangladeshi men.

- Mental illness is also more common among some ethnic communities. A recent report showed higher acute admissions for some BME groups, particularly Black African and Caribbean men. In Westminster, the incidence of schizophrenia is 128 per 100,000 compared to around 40 per 100,000 nationally.

Such discrepancies show the extent of the challenge facing WPCT, and during their presentations senior PCT staff underlined the importance of effectively targeting services to meet the needs of BME communities. They identified the positive shift that could be achieved in the borough's overall health outcomes if good progress could be made in improving outcomes for the 'hardest to reach' groups (this is reflected in a proposed LAA stretch target around smoking cessation, which aims to target smokers within deprived areas and particular ethnic groups).

Addressing BME health inequalities

WPCT representatives highlighted a range of BME-oriented services that they are very proud of – particularly for the borough's Bengali and Arabic communities. They are also a leading NHS provider of interpretation services, and work is being done locally to encourage interpreting as a profession. New Community Health Development Workers represent a promising shift to more flexible, area-based public health work, and this team maintains close relationships with the borough's six neighbourhood renewal partnerships. Some examples of innovative work given were improving meals at homeless hostels; the development of a carers' network; and within mental health, the Arabic Speakers Counselling Project and Oremi day care/outreach services.

WPCT's Service Development Director (Commissioning) Paul Jenkins noted that WPCT has some 'very successful' patient-led partnership groups that monitor different service areas, and in some cases even contribute to appointments. He also emphasised that race equality forms a key part of designing 'patient pathways'. Commissioning at Westminster was seen as 'well-resourced', and a 'joined up' process with Westminster City Council and the local acute trust. He emphasised the 'large commissioning cycle' around the local community and voluntary sector, with one example given of a small grant scheme targeted at smaller community groups working with specific hard-to-reach communities.

WPCT's Chief Executive Lynda Hamlyn explained that the commitment to race equality was owned throughout the organisation. She noted that WPCT aims to recruit from the local workforce, to 'ensure that PCT staff reflect the culture and background of the communities they serve'. WPCT has a 'wide spectrum' of BME staff, but there is much less representation at senior levels. However, she emphasised that targeted training and development was in place – including a successful refugee support scheme within General Practice and Dentistry. Further, following WPCT's last workforce report, any staff without recent training in diversity were scheduled to receive it.

As for other PCTs, the implications of '*Commissioning a Patient-Led NHS*' for the race equality agenda are still unclear. However, WPCT's leadership emphasised its commitment to maintaining a race equality focus. WPCT's PEC Chair stated his belief that, although it would be a challenge in the short term, CPLNHS should lead to good outcomes in the medium and long term.

Going forward

In the meantime, however, the PCT has identified several barriers that must be addressed if it is

to make a 'step-change' in reducing health inequalities. Involving service users and community members in the commissioning process is seen as an important step toward achieving this goal. Drawing on a flow diagram prepared by Melba Wilson of Wandsworth PCT (see Appendix 3), WPCT's Diversity and Equalities lead Brian Colman offered the following assessment of relationship between community engagement and commissioning activity in Westminster.

Needs assessment/community engagement

- *There is a lot of work going on around needs assessment and community engagement – it is increasingly an area of strength for Westminster PCT.*
- *However capacity is an issue – both WPCT's as an organisation and our communities' capacity to engage with us – and this is affected by budgets.*

Priority setting

- *We are beginning to work on our priority-setting process – e.g. through our Race Equality sub-group.*
- *We need creative thinking and working 'outside the square' – beginning with 'what do we want, what are we trying to achieve'?*
- *Some national policies and targets can support our work on race equality, but others can be problematic.*

Service specification

- *There is a lot of work to do in this area. The challenge is to move away from our current patterns of service.*
- *Market management skills are crucial – we need to think about the role of PCTs strategically, and our ability to manage the market – i.e. what do we want to commission, where can we get it from, and if a suitable provider doesn't already exist what will we do? Have we got the right skills to achieve what we want?*

Contracting/SLAs

- *There is a lot of work to do in this area.*
- *There is scope for more community involvement in the contracting process, especially as potential service providers (again some capacity building will be required). Often we don't think about the 'smaller picture' – e.g. the local health economy.*

Monitoring/evaluation

- *Some monitoring/evaluation work has community and user involvement but this is limited. There is the most to do in this area.*
- *Data collection is an issue for the whole NHS, and again budgets are an issue.*

The BME Health Forum

One mechanism WPCT has used for better understanding and engaging with its BME population is its joint sponsorship of an active BME Health Forum. This body is an independent, 'formal bridging structure' between the statutory sector, community and voluntary sector and local communities themselves. Although it draws the inspiration for its work programme from the community, the Forum

reports to and is fully funded by Kensington and Chelsea and Westminster PCTs. It came about as a response to the Race Relations Amendment Act in 2000, which required PCTs to engage with communities. Subsequent policy and planning has strengthened this responsibility.

The Forum presently employs a full-time manager, Amjad Taha, who maintains formal and informal links with several BME communities, and coordinates consultation, advocacy, policy and strategy work around a range of public health and healthcare issues. The Forum frequently acts as a conduit between Westminster PCT and specific BME communities, disseminating health information and feeding back service-users' views and concerns.

However, WPCT's Chair acknowledged that they may be relying too heavily on the BME Health Forum to engage with these communities on the PCT's behalf. This is of particular concern because, to date, the Forum has not been able to reach out to/represent all sections of the varied BME community in Westminster - particularly newer arrivals. Other concerns were also raised during the peer review, which will be covered below during discussion of the team's findings.

'Caught Between Stigma and Inequality'

The BME Health Forum has been behind some very successful work in Westminster; including the recent publication of a report into BME mental health entitled '*Caught Between Stigma and Inequality*', which formed part of the focus of the peer review.

The idea for the project came from the BME community itself. Over 300 people participated in the consultations that underpin the report, with 15 different ethnic communities taking part (out of 35 contacted). Community members were 'involved at all levels, at every step and on an equal basis' in the project – including undertaking consultation work themselves, following training funded by the BME Health Forum. However the Forum noted the limitations of the consultation, as several communities had not participated, and the individuals that had done so were mostly those with access to the community groups involved.

Key findings and recommendations

- BME people are under-represented in primary care, and over-represented in secondary care – their first contact with mental health services is often admission to hospital. More referrals should be made to talking therapies.
- Stigma around mental health is a very big issue among BME communities; negative attitudes are often brought from the country or culture of origin.
- Mental health link workers from BME communities were seen as one way to help reduce stigma, and to help educate BME people about services available. Bilingual befriending schemes and support for community-based services and activities would also help.
- Interpreters should receive training in mental health issues, and NHS staff should receive cultural diversity training.

Westminster PCT's response

An initial workshop was held to 'tease out' the findings and prioritise them. This was seen as 'very positive', as the PCT, Mental Health Trust (MHT) and community groups came together to look at the issues, and an action plan was produced.

Both PCTs and the MHT gave a commitment to work with the BME Health Forum to implement the

recommendations. The local Mental Health Partnership (an overarching body with a membership drawn from the LSP) has set up a Mental Health Race Equality sub-group, of which Amjad Taha is a member. He suggested that this level of engagement has set a welcome precedent in terms of how the PCT responds to BME Health Forum reports.

Mike Jones from WPCT's Mental Health Joint Commissioning Team accepted that there were major challenges to surmount, including Quality Audits, user satisfaction and decommissioning poorly-performing services. However he also set out a range of actions taken in the wake of the report's publication. These included:

- First draft produced of a Delivering Race Equality Strategy (November 2005)
- The Mental Health Promotion Strategy has '*Tackling stigma and discrimination*' as one of its four themes
- Recruitment of a link/community outreach worker – although this post is funded through Race for Health rather than mainstream funding – and a Bengali-speaking graduate into mental health. The PCT plans further such posts
- CMHT involvement with local community/faith groups
- Exploring the translation of self help tools into community languages
- A review of primary care counselling, with a view to addressing its current underutilisation by BME people and those from deprived areas
- Progress on cultural sensitivity within hospital services (e.g. religiously appropriate food choices, gender separation in some wards)

However, although the PCT has been putting a structure in place to deal with the report, the feedback received so far has fallen short of its authors' expectations, and the Forum is concerned that little concrete action has yet resulted.

Presentations made to the team

The preceding pages have summarised the main elements of the presentations made to the Review Team. Less formal small group discussions also took place around three further themes: Healthy Living Centres, Diabetes and Interpreting. These were an attempt to briefly broaden out from the day's theme of mental health and look at commissioning and community engagement 'in the round' within the limited time available.

SECTION TWO

The Review Team's findings and recommendations

Context

Like all PCTs, Westminster is facing turbulent times, and this was recognised by the team. Factors affecting progress on WPCT's work (now and in the future) could include:

- A population in a constant state of flux, with changing needs
- New financing arrangements for PCTs
- New national policy initiatives
- The introduction of practice-based commissioning, and other changes proposed in CPLNHS

However, the team believes that this environment also offers an opportunity to improve on current practice and implement change, for example around service commissioning.

Inequality costs more, and it is a good time to make the business case for doing better for BME service users. The high rate of admissions for BME males into expensive acute psychiatric care - alongside an under-representation in primary care and talking therapies - is one example in Westminster where re-profiling could pay dividends.

Meanwhile, the high-level commitment, optimism and forward momentum of WPCT around race equality must be maintained.

The team emphasised that no PCTs 'had it figured out'; many of the review's findings and recommendations could equally apply to member's own Trusts. In this sense, the review had provided insights and learning for all concerned.

Community engagement

Good practice

The team were impressed by:

- The BME Health Forum – this has real vibrancy, and the PCT's funding and long-term commitment to working with it is to be commended. Further, the Chair's candour about the Forum's limited reach - and possible over-reliance on it by WPCT - demonstrates a willingness to continuously improve engagement.
- Training BME community members to conduct consultation - as happened with the '*Stigma*' report – is empowering for the individuals and should also impact positively on the collection of good-quality data. This new source of expertise should be capitalised on in future work.
- WPCT's ongoing commitment to cultural diversity training for staff should improve engagement with BME service users; however it could be worth evaluating the effectiveness of this training if this is not being done already. The team also applauded the relatively high proportion of BME staff working within the PCT.

Challenges

The team suggested the following areas for further work:

- There are concerns that some of the community engagement work is perceived to be for its own sake: e.g. because it is required by legislation. It is not clear that the PCT always knows what it wants to do with the feedback it receives.
- There is a difference between consultation and involvement of communities, and these shouldn't be collapsed into the same process, as seems to be the case at times. Community and patient involvement should be main-streamed within the work of the PCT, rather than approached in a piecemeal way.
- There are always limits to consultation (e.g. concerns raised about the participation of newer communities) and formal processes will never be a 'catch-all'. Over-reliance on the BME Health Forum and its Manager should also be avoided.
- The PCT needs to give thorough and transparent feedback to communities following consultation or involvement, and the response should not be simply re-stating what is already being done. If the PCT wishes to reject a recommendation, it should say so. Responding to specific pieces of work (such as the '*Stigma*' report) – and ensuring that the necessary connections are made within the PCT - may itself need to be resourced.
- More frequent and substantive community engagement by Primary Care as a whole - and GPs in particular – could help create a better understanding of the issues as they are perceived by BME people.

Using feedback to inform commissioning and re-profile services

Good practice

The team were impressed by:

- WEMNA – the Westminster Ethnic Minorities Needs Audit – is an excellent resource for WPCT. It shows that significant in-roads have been made into understanding local need.
- The PCT's response to the '*Stigma*' report shows willingness to receive BME feedback on mental health services, and there are signs that it is considering how to implement many of the recommendations. The structures set up to address the issues raised by the report suggest a genuine desire to move the agenda forward.
- The appointment of a Bengali-speaking graduate onto the mental health team is a positive step (although this may not be a direct response to '*Stigma*'), as is a commitment to pilot community link workers from BME communities.
- The community health development workers should enable the PCT to better understand and work more closely with its BME communities 'on the ground'. The CHD team's engagement with local neighbourhood renewal work is also very positive, and the LAA stretch target on smoking cessation shows awareness of the potential for wider 'win-win' work.
- Patient involvement in care partnership groups shows an awareness of the importance of embedding substantive community input into service design and monitoring.
- The small grants scheme targeted at voluntary and community groups is a good way to ensure that they can become involved in service delivery, and that the PCT can access 'hard-to-reach' groups. Lessons learned from this small-scale commissioning process could be carried through into more 'mainstream' VCS commissioning (e.g. around performance management, length of funding).

Challenges

The team suggested the following areas for further work:

- One headline finding of the '*Stigma*' report was the over-admission of BME patients into secondary services. Sections and PICU (Psychiatric Intensive Care Unit) placements are very expensive and could be re-profiled – yet it was not clear to the team that savings from strategic investment were seen as opportunities to re-invest locally. Decommissioning services is a challenge for everyone, but 'the nettle must be grasped' if feedback consistently suggests an existing service configuration is not meeting needs.
- Despite feedback from BME communities that they are needed, there is still uncertainty about the future of the BME community link worker posts. It remains unclear how they would be resourced (Race for Health funding will not be viable or appropriate long-term) and how they would 'join up' their work with others tackling similar issues – e.g. the community health development workers.
- It is not clear how community feedback will be fed into actual decision-making (e.g. the LDP). The PCT should take the initiative to 'boil down' feedback for its strategic implications.
- The team also felt that some feedback is not being heard by the PCT, or is not being seen by all of the necessary stakeholders (e.g. the PEC). Routine processes for collecting and processing feedback at the appropriate levels are not yet systematic enough.
- It is critical for the credibility of future community engagement that concrete action is seen to result from major consultation. Even where change is taking place, its nature, pace, or how it is communicated may affect whether the progress is perceived. An implementation action plan with a timeline and named accountability may help.
- The PCT shouldn't automatically assume that service users/community representatives monitoring services can't or don't want to be involved in the 'detail' of service commissioning.

Strategy, connectivity and leadership

Good practice

The team were impressed by:

- It is clear that WPCT staff know what needs to be done, in many cases, and maintain a strong intellectual commitment to race equality within a challenging operating environment.
- Accordingly, the PCT has supported quite a range of innovative work, such as the Healthy Living Centres. A Director-level champion appears to have been critical to the success of the Diabetes Centre, and this could be a good model for other work around race equality.
- WPCT has an excellent resource in its commissioning team. This team, drawing on growing patient and public involvement, should prove a strong force for change.
- Rolling out ethnic monitoring across its services is a key priority for WPCT. As this work progresses, its understanding of the borough's population will be enhanced and the data will provide a good basis for strategic and operational decision-making, particularly around commissioning.
- There are individuals across the organisation with a commitment to improving community engagement, mental health and race equality. The strength of the '*Stigma*' report provides an excellent opportunity to get the right people around the table to move this work forward.

Challenges

The team suggested the following areas for further work:

- Despite the clear commitment of the leadership and staff, questions remain about the follow-through – for example the BME Health Forum produces some excellent work, but it is not clearly linked into the PCT's governance structures (e.g. the PEC Board had not seen the '*Stigma*' report).
- Although the structures that have been put in place are key to success (e.g. the Mental Health Race Equality sub-group), without the resources and authority for action, their work could be undermined. The team also detected possible parallel lines of accountability around BME mental health, which risk fragmentation and duplication of effort.
- There was a sense that the leadership champions race equality, and expects operational staff to 'get on with' the implementation. The team would like to see the Board using regular discussions at its meetings to drive and embed a focus on achieving outcomes for race equality throughout the organisation.
- Connections that are well made through individual champions need to be owned and systemically conveyed throughout the organisation. This is to ensure both that the burden does not fall on a few individuals, and that institutional knowledge (e.g. of past learning and potential ways forward) is not lost.
- Similarly, the PCT's own commitment to race equality should help drive, and be championed through a more assertive commissioning relationship with the major service providers, such as the local hospitals and MHT.
- The strands of work around '*Stigma*' would benefit from relating more closely to the Trust's Race Equality Strategy, so that the vision and direction of travel for BME mental health can be shared within the organisation, with partners in the community and with statutory providers.
- The team were impressed by the clarity of overall intent around commissioning, and hopes that the next stage is to make an explicit link between this and current mental health commissioning. This process should accommodate full input from service users, to enable services to be reconfigured in a way that reflects shared vision and purpose.
- There is already close partnership working within Westminster's health and social care services. The team considered that there was further scope to work jointly with other PCTs, for example by pooling community development workers and sharing good practice through the DRE for London.

LIST OF RECOMMENDATIONS

1. The effectiveness of cultural diversity training for staff should be evaluated if this is not already being done.
2. Training BME community members to conduct consultation is very good practice, and this new source of expertise should be capitalised on in future work.
3. Consultation and involvement of communities should not be collapsed into the same process. Community and patient involvement should be main-streamed within the work of the PCT, rather than approached in a piecemeal way.
4. Over-reliance on the BME Health Forum and its Manager should be avoided.
5. More frequent and substantive community involvement by Primary Care as a whole - and GPs in particular – could help create a better understanding of the issues as they are perceived by BME people.
6. WPCT should be clear in advance what it will do with any feedback it receives from the community. In particular:
 - The results of formal consultations like '*Stigma*' should be seen by all of the necessary stakeholders (e.g. the PEC) at all levels within the PCT.
 - The PCT should take the initiative to 'boil down' feedback for its strategic implications, and clarify how it will be fed into actual decision-making (e.g. the LDP).
 - The PCT needs to give a thorough and transparent response which should not be simply re-stating what is already being done. An implementation action plan with a timeline and named accountability may help.
 - It is critical for the credibility of future community engagement that concrete action is seen to result from such a process. If the PCT does not intend to act on a recommendation, it should say so.
7. Rolling out ethnic monitoring across its services should remain a key priority for WPCT, to provide a basis for strategic and operational decision-making, particularly around commissioning.
8. Lessons learned from the small grants scheme targeted at voluntary and community groups could be carried through into more 'mainstream' VCS commissioning (e.g. around performance management, length of funding).
9. The PCT shouldn't automatically assume that service users/community representatives monitoring services can't or don't want to be involved in the 'detail' of service commissioning. Mental health commissioning should accommodate full input from service users, to ensure services will be fit for purpose.
10. It was not clear to the team that savings from strategic investment were seen as opportunities to re-invest locally. Decommissioning services is a challenge for everyone, but 'the nettle must be grasped' if feedback consistently suggests an existing service configuration is not meeting needs.
11. The PCT's own commitment to race equality should help drive, and be championed through a more assertive commissioning relationship with the major service providers, such as the local hospitals and MHT.
12. The PCT should clarify its intentions around the BME community link worker posts, and ensure that they 'join up' their work with others tackling similar issues – e.g. the community health development workers.
13. The BME Health Forum should be clearly linked into WPCT's governance structures, and connections that are currently made through individual champions need to be owned and

systemically conveyed throughout the organisation.

14. The Board should use regular discussions at its meetings to drive and embed a focus on achieving outcomes for race equality throughout the PCT.
15. The strands of work around '*Stigma*' would benefit from relating more closely to the Trust's Race Equality Strategy, so that the vision and direction of travel for BME mental health can be shared within the organisation, with partners in the community and with statutory providers.
16. The PCT should ensure that any parallel lines of accountability around BME mental health are identified and resolved. The '*Stigma*' report provides an excellent opportunity to get the right people around the table to move this work forward.
17. There is further scope to work jointly with other PCTs, for example by pooling community development workers and sharing good practice through the DRE for London.

Appendix 1: Peer Team Biographies

Daisy Camiwet

Patient and Public Involvement Manager, Lambeth PCT

A qualified nurse, Daisy worked with community based health programmes, women's health and gender development in the Philippines for over 10 years. She later moved into anti-poverty work and the promotion of equalities and diversity in the UK within an international development agency, the voluntary sector and within the NHS, and gained an MSc in Health Services Management. Now the PPI Manager at Lambeth PCT, Daisy is experienced in participatory and community development approaches to promoting social inclusion in service development within the NHS and the voluntary sector.

Una Dalton

Director of Human Resources and Corporate Affairs, Lambeth PCT

Una has worked in the NHS since 1989, mainly in Human Resources. She became Lambeth PCT's Director of HR and Corporate Affairs in November 2003 having working in a number of PCTs, the former London Regional Office, East London and The City Health Authority and the Royal Marsden Hospital.

Errol Francis

Thinking Partner, Westminster PCT

Errol Francis is Joint Programme Lead at the Sainsbury Centre of Mental Health 'Breaking the Circles of Fear' programme. Errol has worked in the voluntary sector and the NHS for 20 years setting up specialist services for African Caribbean people, including one of the UK's first independent black mental health services in Brixton in 1982. He has written widely on mental health issues and is a regular contributor to conferences, training and education.

Helen Hally

Programme Director, Race for Health

Helen is a nurse and a psychotherapist, and has worked in a variety of clinical, educational and managerial roles. In addition, she has been involved in a range of performance review and policy development initiatives, from the development of a national strategy on women's mental health to public inquiries into homicides. Before her appointment as Race for Health's new Programme Director in July 2005, Professor Helen Hally was Director of Nursing at Haringey Teaching PCT.

Grant James

Mental Health Commissioning Manager, Bradford PCT

A qualified social worker, Grant has worked in a wide range of health and social care settings in Yorkshire, South Wales and the West Country. After seven years as a probation officer, he became Mental Health Resettlement Officer in Barnsley, developing community living schemes. Grant then worked in Kirklees for 12 years in a variety of capacities, including managing a centre for older people with dementia and challenging behaviour, managing an integrated SMI Team, and working with the voluntary sector as Mental Health Contract and Service Development Manager. He returned just over a year ago from 18 months in Rotherham, where he managed an integrated CMHT.

Stephen James

Head of Partnerships and Diversity, Ealing PCT

Stephen has a background in partnership development, community liaison, and work within the voluntary sector. Prior to joining Ealing as its Head of Partnerships and Diversity, he managed a west London-wide Renewal SRB Programme which helped refugees overcome barriers in accessing health, employment and services for young people and families. Stephen also led the development

of Healthy Living Centres in three London boroughs under the auspices of the New Opportunities Fund. Earlier in his career, Stephen led HIV voluntary organisation Body Positive (London) and Kensington and Chelsea MENCAP.

Paul Jeff

Senior Project Officer, Department of Health

Paul Jeff joined the Department of Health's Equality & Human Rights Group (EHRG) on 28 November 2005. He is a Senior Project Officer with an interest in the Pacesetters and Race for Health Programmes. From 2000 to 2005, Paul worked in a variety of posts within the Department of Health and the Department for Education and Skills on children's social care. These included policy development on raising the educational attainment of looked-after children. For the past 2½ years, Paul has been working on the development of regulations and guidance as part of the work programme to implement the Adoption and Children Act 2002.

Jitesh Joshi

Equality and Diversity Manager, Eastern Leicester PCT

After four years as a community health development worker focusing on the BME communities of Leicester, Jitesh recently took up a new role as the Equality and Diversity manager at Eastern Leicester PCT. He now provides advice at a strategic level and ensures that equality and diversity are central to all functions within the PCT. Jitesh's background is within the local authority, where he worked for 14 years in community development and management, including play and youth services. He brings considerable experience of working with people from a variety of backgrounds, having worked across all neighbourhoods in Leicester.

Angela Neblett

Head of Strategy and Commissioning - Mental Health and Substance Misuse, Camden PCT/LB Camden

Angela has ten years management experience in the NHS, but also has a strong commitment to forging greater links with, and developing, voluntary sector service provision. Having taken a lead role in the commissioning of specialist mental health services for North Central Sector, it seemed 'an apt time to step down the patient pathway' and focus on mainstream services. Angela has recently been appointed by Camden as Head of Strategy and Commissioning Mental Health and Substance Misuse, a joint role between the PCT and local authority.

Naim Razak

Community Health Development Worker, Eastern Leicester PCT

Naim works as a Community Health Development Worker in Eastern Leicester, covering the Highfields area, one of the most diverse communities in the Midlands. Acting as the link between the community and the PCT, Naim takes a holistic approach to empowering community members to take better control of their lives and improve their health. He has over 22 years experience working with communities as a playworker, youth worker, activities organiser and community development worker, and has experience of working for both the statutory and voluntary sector in community health development.

Melba Wilson

Chair, Wandsworth PCT

Melba combines her role as Chair of Wandsworth PCT with ongoing work in mental health policy and service development. Most recently, she has led a programme of work at the Greater London Authority, which aimed to develop initiatives for black and minority ethnic mental health service improvement. She is about to take up a new position as Director of Race Equality at the London Development Centre for Mental Health. Melba is also Deputy Chair of the London Health Commission,

which affords the opportunity to develop strategic approaches and partnerships for improving health and reducing health inequalities.

Shared Intelligence Race for Health Learning Programme Advisors

Sue Charteris

Director, Shared Intelligence

Sue is a senior public policy consultant specialising in local government and public service reform, and is a founding director of Shared Intelligence (Si). She has a wealth of expertise in strategy and policy development, organisational development and knowledge exchange, and leads many of Si's learning network programmes.

Rebekah Brumwell

Consultant, Shared Intelligence

Rebekah works as a consultant and project manager, and has particular expertise in supporting peer reviews. Most recently, Rebekah worked on prototype peer reviews of the Museums, Libraries and Archives Council and Arts Council England on behalf of DCMS.

Appendix 2 - Westminster PCT participants

Dr Dennis Abadi

Professional Executive Committee (PEC) Chair, WPCT

Fidelma Carter

Head of Community Health and Partnerships, WPCT

Brian Colman

Equalities and Diversity Manager, WPCT

Alison Devlin

Equalities Manager, Central and North West London Mental Health Trust

Catherine Dolbear

Head of Public Health Intelligence, WPCT

Amira Gorani

Community Health Development Coordinator, WPCT

Margaret Guy

Director of Public Health, WPCT

Lynda Hamlyn

Chief Executive, WPCT

Joe Hegarty

Chair, Westminster PCT

Paul Jenkins

Director of Service Development, WPCT

Mike Jones

Mental Health Service Manager, WPCT/CWC

Mahebab Ladha

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Linda Sheridan

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Amjad Taha

Manager, BME Health Forum (WPCT and K&C PCT)

Razia Tahir

Programme Manager, Church St Healthy Living Centre

Anna Waterman

Community Health and Regeneration Manager, WPCT

Appendix 3 - The commissioning process

(Melba Wilson, Wandsworth PCT)

