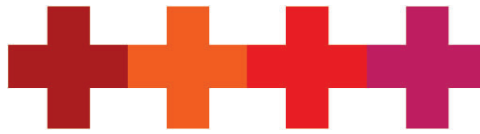


race for health



a transformational change programme

Wandsworth PCT Peer Review

22nd – 23rd February, 2006

Outcome paper

Introduction

The Wandsworth PCT Peer Review took place on the 22nd and 23rd February, 2006.

The visiting team of Peers included representatives from Central Manchester, Ealing, Eastern Leicester, Lambeth and Westminster PCTs. The team also included Wandsworth's Race for Health Thinking Partner, the National Director of Race for Health, 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 Wandsworth PCT's management, including its Chair, Chief Executive, PEC Chair and Director of Public Health. The team also had the chance to speak to a range of PCT staff at various grades and from different directorates/services; and to meet with representatives from the community and voluntary sector. 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 the PCT's work in the area considered.

Theme and key questions for the Review

The theme for the Peer Review was:

How successfully is Wandsworth PCT communicating its race equality agenda to its staff, partners and the communities it serves, and is this being translated into more effective service commissioning? Are the 'messages sent' the 'messages received', and are people aware of progress made on the ground?

The key questions the team considered were:

- Is Wandsworth PCT's clear commitment to race equality being effectively communicated throughout the organisation? To what extent is this commitment being reflected in its commissioning?

- Are management and staff aware of the work being done by the PCT in this area, and any key successes and challenges?
- More widely, how well is WPCT's race equality commitment known and understood by:
 - The PCT Board and the PEC Board
 - The local Acute Trust
 - Other NHS management and staff
 - Service users and the wider community – particularly BME groups
- Do these individuals or groups appear to have any difficulty with/resistance to the level of priority given to race equality, and its impact on commissioning? How do they personally believe they should be moving race equality forward, and how does this compare with the expectations of the PCT's leadership?
- What structures are in place to enable the PCT to communicate with these varied audiences? Are there any particular instances where this has worked very well, and less well?
- Does this have any wider implications for Wandsworth PCT's communications function?

SECTION ONE

Background and context

Population

In terms of population size, Wandsworth is one of the largest boroughs in the Greater London area with around 270,000 residents. Over the last ten years, the borough's population has changed. Today, 53.7% are aged between 20-44 years: a strikingly high percentage when compared to the same age group for England/Wales and London at 35.1% and 42.8% respectively. By contrast, Wandsworth has a much smaller proportion of older people and young children (aged 5-14) compared to the UK national average.

One characteristic of the younger population is high mobility. In the last year alone, over one in five of the borough's residents relocated to Wandsworth with approximately 50% of those moving to the area from elsewhere in the UK. Indeed, Wandsworth has the most mobile population in England and as a consequence many residents are not registered with local general practices.

Its geographic location and a strong housing sector combined with business expansion has attracted the young, healthy, wealthy and highly educated. More than 47% of the population have qualifications at degree level or higher compared to 19.8% for England and Wales. Many residents are identified as single and never married (54%) with one-person households in Wandsworth reaching 37%.

Ethnicity

Wandsworth has a smaller proportion of the population who describe themselves as White British (65%) than the average for England (87%), but a larger proportion than the average for London (60%). Wandsworth has over 3 times the national average of White 'Other' residents and over twice the national average of White Irish.

The other major ethnic groups in Wandsworth are Black Caribbean, Black African, South Asian (Pakistani and Indian) and mixed race. Tooting and Graveney and the South Eastern section of

Wandsworth have the highest percentage of Asian communities; Black communities account for a significant proportion of the population in Latchmere, Queenstown and Furzedown.

Refugees and asylum seekers represent a small proportion of the population in Wandsworth. However this small group - estimated to be between 200-300 people – can make significant, specific demands on health services and social care.

Health in Wandsworth

Quality of life and level of deprivation are the main factors that influence people's health in Wandsworth. There are substantial variations in both health status and access to health services between the most deprived wards (e.g. Latchmere) and the most affluent (e.g. Thamesfield).

In addition to the wider determinants of health (for example housing or unemployment), the top risk factors for disease and poor health in Wandsworth include unsafe sex, high blood pressure, tobacco and alcohol consumption, poor hygiene, pollution and lack of exercise.

Poor mental health, high stress levels and limited coping skills are also risk factors in Wandsworth. The 2002 review of mental health service provision for working age adults in England found that Wandsworth has an above average number of people in contact with specialist mental health services, compared with the average for South West London and London as a whole.

The main causes of death in Wandsworth are cardiovascular and cerebrovascular diseases (mainly coronary heart disease and stroke), cancers and respiratory diseases. This is similar to England as a whole and to other parts of London.

Wandsworth PCT

Wandsworth PCT (WPCT) has a budget of £380m to provide and commission a wide range of health services. It supports the work of 53 GP practices and employs over 1,800 people.

WPCT provides community nursing and therapy services from a variety of locations, including health centres and clinics, GP surgeries, schools and peoples' homes. Services include district nursing, health visiting and a Walk-In Centre based in the grounds of St George's Hospital in Tooting. The PCT also manages Queen Mary's Hospital Roehampton, which provides a wide range of community services including inpatient beds, outpatient clinics, a minor injuries unit and a sexual health clinic, as well as the world famous amputee rehabilitation centre.

In addition to these services, the WPCT Public Health team develops and coordinates a number of projects to improve the health of people in Wandsworth. These are wide ranging and utilise a partnership approach both within the PCT and with external agencies such as Wandsworth Council, service providers, the voluntary sector and communities.

BME groups are over-represented amongst the overall PCT workforce in comparison to the communities served, but are currently under-represented amongst senior management.

Achieving race equality in health

Race inequality vs. health inequality

One of the key issues faced by WPCT in achieving race equality in health is understanding the link between health and ethnicity in the borough. This link is seen to be less 'direct' in Wandsworth

than in many other areas, although the borough's most deprived areas (also those with the least healthy populations) are those with the highest proportion of black and minority ethnic residents. However WPCT's Director of Public Health, Dr. Salman Rawaf argues that ethnicity is not necessarily in itself a key factor in health inequality.

Wandsworth's black and minority ethnic (BME) residents fall into three broad categories. The first group are third or fourth generation UK citizens and are relatively affluent; many have high levels of education, are economically active and of average health status. The second group are more recent migrants to the UK, and may have language needs or higher health needs than their White British neighbours. The third group is made up of refugees and asylum seekers, and this group is both much smaller and more prone to fluctuation than the others. This group tends to suffer high levels of deprivation and poor health and have significant language needs.

The heterogeneity of Wandsworth's BME population does challenge simple generalisations of ethnicity as a determinant of health, and strengthens the case for the primary link being between health inequality and deprivation. However some WPCT staff emphasised that this does not negate ethnicity as a potentially significant factor in terms of access to services, experience of healthcare (e.g. discrimination, cultural appropriateness), high risk lifestyles and behaviour, and response to treatment. The team were not clear as to what constitutes the 'corporate view' on the link between race equality and health inequality.

Needs-led commissioning

Within WPCT there is a consensus that race inequality in health can be at least partly addressed by focusing on reducing health inequality overall; and in particular through a shift toward needs-led commissioning. This approach should favour deprived individuals and communities who tend to have higher health needs, including those from BME groups, and should also help ensure that services are more responsive to changing populations.

WPCT expresses a strong commitment to needs-led commissioning and is already working towards providing services to its population on this basis. Examples of this relevant to the race equality agenda include:

- Recruitment of Tamil speaking diabetes workers
- Commissioning of a pilot survey on mental health in Wandsworth, to obtain benchmark data on community mental health
- Targeted efforts during Ramadan to encourage healthy eating
- Partnership-working with groups such as ASWAC (the Association of Somali Women and Children) on preventative work specific to the Somali community; for example, raising awareness around the risk of oral cancer from chewing tobacco
- Provision of translation and interpreting services – e.g. in primary care (although the uptake of these services still needs to be assessed)

However, WPCT faces some real challenges in its drive towards needs-led commissioning.

Ethnic monitoring and needs-led commissioning

To commission effectively services that reflect the needs of its residents, WPCT must be able to compare the demographic profile of its overall population with that of its service users, and ensure that it has a sophisticated understanding of different groups' health needs, access to existing services and past experiences of care.

To do this, both ethnic monitoring data and 'frontline intelligence' must be systematically collected throughout directly provided and commissioned services, analysed and fed into the commissioning process. However, levels of data collection throughout the NHS are often insufficient for this task, particularly in primary care. This seems to be the case in Wandsworth.

One key factor that has led to low levels of collection in primary care is that GP contracts have no requirement to collect ethnicity and language data. In the past WPCT has used the incentive of QOF 'platinum points' to reward voluntary data collection. While this has increased ethnic monitoring to some extent, many GPs and other primary care providers still fail to understand the clinical or business case for routine collection, and consequently do not undertake it. Although financial incentives show WPCT's commitment to increasing ethnic monitoring in general practice, there is no penalty applied for not collecting ethnicity data.

In the absence of a robust intelligence base, it will be difficult to move towards needs-led commissioning. This is reflected in the PCT's Race Equality Scheme, where 'improving ethnicity monitoring' is an agreed action.

Financial constraints

Financial constraints within the NHS affect all aspects of the PCT's work, including service commissioning and delivery and HR. A programme of redundancies has affected staff morale; however the PCT believes that it can now benefit from a more efficient and effective structure. WPCT is confident that needs-led commissioning will help get the best possible value from its £380m annual budget, and it has set up a Strategic Commissioning Group to guide this process.

Communicating the race equality agenda

Going forward, WPCT recognises the importance of ensuring that the logic for this shift - from 'historical' patterns of service to needs-led commissioning - is widely understood and supported. Any decommissioning that needs to take place as a result must also be properly explained and placed in context. The race equality agenda and, more widely, health inequalities form a key part of these discussions, and stakeholders include staff, providers, partners, service users and the wider community.

This is a key role for WPCT's communications team, its leadership, and ultimately for all PCT staff in a public-facing role. However, as well as disseminating messages 'outward', feeding data and stakeholders views back into the centre will help to shape the services delivered by the remodelled PCT and ensure they are fit for purpose.

The communications team

WPCT has a dedicated communications team that is responsible for disseminating information both internally and externally - to WPCT's providers, partners and the community.

Internally, the communications team disseminate information to PCT staff through a series of publications, including a weekly e-bulletin, quarterly newsletter and annual report. The communication team also organise staff briefings by the PCT's Chief Executive and Chair. WPCT will soon have an intranet, which will provide an accessible forum for information-sharing for all PCT staff. The communication team anticipates that discussion boards on the intranet will encourage more information sharing within the PCT.

The communications team also design and produce a wide range of health-related printed materials for external use, and hold public events to raise awareness and disseminate information. WPCT has also been making 'significant improvements' to its website and is seeing a rise in the number of daily hits.

Equality and diversity in communications

The team expressed a clear commitment to reflect the diversity of WPCT's staff and population in WPCT communications. As well as basic practices - for example, ensuring that they maintain a photo library that reflects the diversity of the staff and the population they serve - specific examples provided to the review team include:

- An equality and diversity bulletin
- An information booklet on ethnic monitoring
- An Equality and Diversity section on the WPCT website, which includes:
 - Information on Equality Impact Assessments (EIA)
 - Policy documents related to equality and diversity
 - Health information in different languages
 - Links to translation websites
 - Diversity training opportunities within WPCT
- Publicity materials advertising support for people suffering from discrimination
- Black History Month events

A bring and share meal at the PCT head office celebrating staff diversity

Patient and Public Involvement (PPI)

As part of their session with the communications team, review team members also met with WPCT's PPI Manager, Colin Smith. Race equality activities - and in particular, community engagement – appear to be very well woven into PPI activities. PPI is a core focus for WPCT's diversity committee.

The PPI Manager has an in-depth understanding of equalities issues, and tries to ensure that patient involvement activities embrace and reflect the diversity of Wandsworth's population. PPI is instrumental to many of the PCT's consultation and engagement activities, including its innovative PPI database and community events with faith, asylum-seeker and refugee communities. The PPI Manager is also working with a community group to ensure that consideration of BME and refugee and asylum seeker communities is embedded within practice-based commissioning activities.

Implementing race equality in health

Commissioning and service delivery are critical links in the chain for WPCT as it seeks to address the race equality and health inequality agendas. Accordingly, service providers (both internal and external) must understand how these agendas relate to their work and be convinced of the PCT's approach.

Commissioning and service delivery

The review team met with the Director of Provider Services at WPCT, the Chief Executive of St. George's Hospital (a local acute trust from whom WPCT commissions services), and the Practice

Manager at a local GP surgery, Brocklebank Health Centre, to discuss race equality.

St George's Hospital in Tooting is one of the biggest NHS hospitals in the country, and treats around half a million patients a year. It provides accident and emergency, maternity services and care for older people and children, and is also a leading national centre for more specialist care including neurology, cardiac care and cancer.

Brocklebank Health Care Centre is one of 22 practices that are part of a commissioning cluster called the Wandle PbC cluster. Brocklebank has eleven GPs (including WPCT's PEC Chair Tom Coffey) and 15,000 registered patients, of which 55% are BME. It also manages Southfields Practice, a single-handed satellite practice.

The key points that emerged from these discussions are listed below.

Provider services

- Managers and frontline staff have received excellent training around race equality through Margaret Adjaye, Diversity Facilitator at WPCT.
- Equality Impact Assessments are happening, but are in the main paper exercises. There is still a challenge around embedding race equality in day-to-day practice.
- Structural and service change should provide a good opportunity for gaining further clarity about where there are gaps to be addressed. The aim is for collective learning from past experience and best practice to be captured in WPCT's business planning, going forward.
- There has definitely been a change of culture – the reality is that PCT provider services must become very fit for purpose, lean and quality-driven to compete in the new environment. Providing there is good evidence that needs-led commissioning is the best way to go, most staff will go along with that.
- The evidence base is not without gaps, but ethnic monitoring in provider services has considerably improved. However there is still a lack of clarity about how data and feedback is being used elsewhere within the PCT.

St George's Hospital

- WPCT's leadership demonstrate a high level of commitment to race equality - both St. George's Hospital and the PCT itself have benefited from this lead.
- The PCT's Diversity Committee have generated useful ideas which have been fed back to St. Georges.
- While there has not been sufficient priority accorded to race equality in the past, the issue is now being given greater attention following key appointments, including the joint appointment of Margaret Adjaye as Diversity Facilitator.
- St George's aim to move from compliance with statutory requirements to tackling race equality as an integral element of good quality service provision. An example of this its approach to ethnic monitoring, where all directors are soon to be held to account for improving levels of monitoring.

Brocklebank Health Care Centre

- Brocklebank Health Centre clearly sees ethnic monitoring of patients as a priority. The practice has identified several difficulties around data collection and is using cash incentives and a team approach to tackle these. It has trained its staff to collect data through role-plays and has done work around asking patients difficult questions, collecting data from established patients and collection throughout care and treatment. Brocklebank has increased its ethnic monitoring

levels from 32% in 2005 to 64% in 2006.

- Brocklebank is becoming more confident at raising race-related issues through the PbC cluster, and communication channels are starting to open with WPCT in relation to race equality issues. One area of concern is 'selective registration' by GP practices, which may disadvantage BME patients seeking to register.
- Communication is good between Brocklebank and WPCT around clinical and strategic issues.

A community perspective

The review team also met with representatives from the local voluntary and community sector, including the Wandsworth Community Empowerment Fund, the Sickle Cell Support Group and the Multi-Faith Group; and with a group of refugees and asylum seekers.

The PCT's leadership is regarded as very proactive in the area of race equality and the work of the Diversity Facilitator, the Chair and the Chief Executive were specifically commended. WPCT is also seen to be doing well on communication.

Specific comments made included:

- At times, WPCT's consultation work can feel too much like a 'tick-box' exercise.
- Diabetic care for older Sikh and Hindu people – who often have language difficulties - could be improved by bringing services to them.
- Mental illness amongst young Asian mothers is not being consistently picked up.

The treatment of Sickle Cell patients was a particular area of concern for some participants. The following points were raised:

- There are no protocols in place for the management of Sickle Cell, and a lack of properly trained staff to deal with Sickle Cell cases. GPs often don't know how to manage sickle cell patients, and they may not be treated until at crisis level.
- Often patients do not receive drugs, or they receive them at a late stage.
- Patients do not like going to hospital as a result of some staff's behaviour and attitudes. An example was given where some patients have been called drug addicts by nursing staff, or have been told that children contract Sickle Cell because of the 'mother's sin'.
- Patients with Sickle Cell have been sent home from St. Georges Hospital before they have fully recovered. There is a dedicated ward of 16 beds, but patients with other medical conditions are often nursed there.

Refugees and asylum seekers

Members of the review team met with Rhian Williams, a Health Visitor employed to work specifically with refugees and asylum seekers in Wandsworth, and a group of her clients accompanied by interpreters.

Ms. Williams' clients spoke of the hardship they had faced upon arrival in Wandsworth; often speaking no English, having no contacts in the UK and still coming to terms with traumatic experiences in their country of origin. All of those present were clearly very grateful for the service they had received, were full of praise for Ms. Williams and her co-workers and welcomed the opportunity to express their thanks.

Additional points made were:

- Many of the group had arrived with or developed multiple health needs, and their contact with the Health Visitor service provided an access route into primary and secondary care as well as a range of other local services. In some cases health conditions were able to be treated prior to becoming serious and requiring expensive acute care.
- Both the client group and their interpreters (who work across several London boroughs) feel that WPCT respond to the needs of this user group much more effectively and humanely than other PCTs.
- However one area of concern is that refugees and asylum seekers are often not offered an interpreter (e.g. by a GP) unless specifically requested to by the Health Visitor. It is clear that many NHS staff regard friends or family members as acceptable interpreters.
- Relying on individual champions is not a sufficiently robust long-term strategy. WPCT must continue to develop a culture where all staff are 'champions'.

Workforce and organisational development

Members of the Review Team met with PCT staff members from the Organisational Development team and from the Minority Ethnic (staff) Forum. Key points made by WPCT staff at these discussions are listed below.

Organisational development team

- Promoting equality at WPCT is seen to include the development of both the organisation and its staff, and BME staff are able to access targeted development programmes.
- While good training opportunities are available around equality and diversity, they are more likely to be taken up by staff who are already actively engaged in this agenda - whilst those who would most benefit tend not to take advantage of them.
- There is also a perception that the PCT has high levels of disciplinary action against BME staff.

Minority Ethnic Forum

- The Minority Ethnic Forum (MEF) is pleased with the support from the Diversity Coordinator, and welcomes the commitment of WPCT's leadership to this agenda.
- Although corporate data about learning and development opportunities broadly indicate equity of access, the perception of many BME staff is that they face additional barriers that are not currently being addressed. There is a need for the MEF and managers in learning and development to explore together the validity of the corporate data and address any barriers.
- The biggest challenge for the MEF has been its remit in terms of the PCT's Race Equality Scheme (RES). The MEF and the Diversity Committee are joint partners in scrutiny of the RES, and the MEF were encouraged that WPCT was investing this responsibility in them.
- However, there is a list of 20 actions for the MEF to be involved in, and there has been no formal process to look at its capacity to be involved in this level of activity.
- A lot of data for the RES was not submitted for the last year. Although this is seen in the context of the pressures of restructuring, it suggests that the RES is not seen as a priority by some within the organisation. Reporting by directorates of progress made against RES priorities needs to be improved if the Trust is to effectively evidence and publish its race equality activities.

SECTION TWO

Findings

Good practice

Wandsworth has several examples of very good practice in engaging with its BME communities, and taking forward its commitment to diversity and equality within the PCT.

Moreover, despite a number of excellent initiatives and overall progress on the diversity agenda, the Review Team did not pick up any complacency. The PCT's senior management team are committed to moving to needs-based commissioning and a 'fit for purpose' organisation able to deliver this.

The peer review team was impressed by:

Communications

- An organisational commitment to communication, backed up by a dedicated communications team.
- The communications team is well staffed, and appear to be innovative and proactive in their methods of communication. They have produced some excellent materials – e.g. the Ethnic Monitoring Handbook.

Service Provision

- Some excellent intelligence gathered by Public Health.
- Brocklebank Health Centre (BHC) have doubled their ethnic monitoring rates from 32% to 64% in a year – this is impressive progress. Further, as a driver for Practice-based Commissioning and the development of their 'cluster', BHC hope to roll out their approach to ethnic monitoring to all practices in the Wandle cluster.
- Some of the ideas that are generated by the PCT's E&D committee have been picked up by St. Georges Hospital.
- The Refugee Registration Scheme, and the excellent work of the refugee and asylum seeker Health Visitor, Rhian Williams and her team.

Community engagement

- The PCT's engagement with the LSP faith group – e.g. consistency of representation at meetings and a perceived openness to dialogue - and this group's innovative Culture and Faith Directory.
- The Association of Somali Women and Children (ASWAC) - an excellent model for engagement with specific communities.
- The Tamil Group's involvement of the community and GPs in a project which revealed the stigma associated with mental health issues, and the need to promote the concept of Positive Mental Health. Understanding the priority issue, the different terms used in Tamil culture and the types of materials which were most suitable for engaging this community had resulted in production of a Tamil translation of a guideline for Post Traumatic Stress.
- The PPI database – this is innovative, has achieved excellent response rates to consultations and has high BME involvement.
- The 'How was it for you?' survey - although not systematic, it is a promising mechanism for getting patient feedback.

- Recruitment of lay-people as QOF assessors, and inclusion of a lay representative on the PEC.

Workforce and organisational development

- A diverse senior management team, who bring ambition, courage, commitment and a corporate approach to the diversity and equalities agenda.
- Ongoing support for the Diversity Facilitator post, despite financial pressures – and wide support and respect for her achievements to date.
- Increasing use of Equality Impact Assessments – e.g. of the recent job restructuring/ redundancy process.
- Scrutiny and review of the PCT's Diversity Committee, to ensure its membership reflects diversity and equalities as core business.
- The potential for wider access to development opportunities for BME staff already provided by WPCT, and for closer links between the corporate race equality agenda and the Minority Ethnic Forum.
- The cluster leads feedback group – this is a powerful forum for taking forward an understanding of race equality issues and dealing with challenges.

Questions and challenges

However, there were some areas where the Review Team identified challenges, or where questions remained.

Communications

- The communications team is using many different strategies to get messages out. However, the review team did not see any evidence of a clear strategy to ensure that the messages sent are the messages received, and that feedback from these audiences/stakeholders is informing commissioning.
- More generally, it appeared that although a great deal of effort goes into putting new initiatives/ mechanisms in place, and preparing and disseminating key messages, measuring their impact and monitoring staff/user responses to them receive less attention.
- Similarly, when feedback is collected from staff, patients and partners, the PCT does not necessarily communicate any findings/conclusions/actions back to those it has consulted – i.e. 'completing the loop'. There may be a problem of information being held in silos.
- The team did not see evidence of an overt and explicit race equality message, although ethnicity considerations are found as part of their overall communication messages. This may be in part a reflection of the PCT's ambivalence about whether in Wandsworth the prime determinant of health outcomes is ethnicity or deprivation. Unlike many inner-city areas, these two dimensions are not co-terminus in Wandsworth.
- The senior management team's appreciation of how widely and well-understood the PCT's high level priorities are amongst PCT staff, CVS partners and others may be over-optimistic.
- Targeting the non-English speaking population is another area for development, especially as many of the materials produced by WPCT are written in English. As cost is a real limiting factor to printing in different languages, the Communication Team may have to be more innovative about how they engage with this section of population.

Service provision

- The PCT's commendable commitment to needs-based commissioning will rely on comprehensive and high quality data, analysis and consultation. The review team felt that the

necessary mechanisms and processes to support this require further development.

- Data collected by directly provided and commissioned services is neither being interrogated/used in-situ, nor systematically fed back to them in a useful format from the centre. It is therefore not clear to those supplying the data if or how it is being used, or what any analysis has shown.
- From the perspective of the Sickle Cell support group, there are some major challenges and gaps around treatment, patient support and strategy for Sickle Cell.

Community engagement

- Some points have been covered under 'Communications' above.
- WPCT has difficulty engaging with its largest population group – who tend to be young, relatively affluent, mobile and educated. Although a focus on excluded/deprived groups is understandable, there does not appear to be any strategy for reaching this population.

Workforce and organisational development

- There was some considerable confusion around key PCT messages about the overlap between health inequalities and race equality, and how these were being addressed together and/or separately. This was especially apparent in Public Health, and may lead to inconsistency of understanding and focus amongst WPCT staff as a whole.
- The WPCT Minority Ethnic Forum is a mechanism with great potential to drive the diversity and equalities agenda and to empower BME staff. It has been given a major scrutiny role in relation to the RES, and there could be scope for more strategic, proactive work – however, there appear to be very real capacity and morale issues.
- The PCT believes that BME staff get the same training and development opportunities as others, and its own mapping exercise supported this view. However this is still not the perception at the frontline.
- WPCT's workforce has an overrepresentation of BME people at many levels, but not at middle management level - particularly within the commissioning team. The review team understands that there is ongoing work around this.

Recommendations

The Review Team makes the following recommendations:

Communications

- Race inequality vis-à-vis health inequality: although there are very similar issues around these agendas, they are not the same. The 'corporate view' of how they fit together – in relation to BME need, access and experience – needs to be clarified and re-stated to avoid confusion.
- There is a structural issue around 'silos' and passing information from one place to another – the PCT needs to do some problem-solving around these issues, e.g. by tasking cross-disciplinary groups (with board champions) to look at sharing intelligence.
- Further, the 'communications loop' needs to be completed – i.e., the PCT must feed back after soliciting data and qualitative feedback, preferably with the results of its analysis, emerging key messages and priorities, and the implications for services, systems or commissioning. This applies to consultation/communication with patients and patients groups, the wider community, CVS and statutory partners, and staff.
- Public health information in particular should be systematically fed back into services.

Workforce and organisational development

- Equality and diversity is a core dimension of the Knowledge and Skills Framework (KSF). The KSF is useful as an objective framework for retaining talent, succession planning and evaluating individual performance and should therefore be a strong lever for promoting competence in managing diversity.
- WPCT should utilise the Minority Ethnic Forum to explore further the perceptions of BME staff around access to learning, development and promotion. If the MEF is to effectively fulfil a role in monitoring implementation of the RES, then there needs to be closer involvement of the MEF with the corporate agenda and better access to data. There may be some resource implications with the latter recommendation.
- The PCT should ensure that an understanding of the needs of refugees and asylum seekers is built into learning and development for primary care staff. For example, it could develop more opportunities for the Health Visitor's team to raise awareness throughout the PCT and the local health economy, e.g. by 'training the trainers'.

Service commissioning

- Where data analysis does reveal trends, areas of concern etc., or frontline/user/community 'intelligence' is robust and well-supported, this should be fed into the PCT's mainstream commissioning.
- Where there is a new initiative or mechanism set up (internally or externally), WPCT should ensure that a follow up/monitoring process is built into it to enable ongoing analysis of impact, and systematic collection and dissemination of feedback from staff and users.
- WPCT should continue to embed Equality Impact Assessments in daily practice at all levels – extending them further, beyond policy and documentation, into all aspects of service provision.
- Discussions with the review team suggested that WPCT needs to urgently develop and implement a sickle cell strategy. The PCT also needs a greater awareness programme, including promoting youth awareness of the disease. The team would also recommend an advocate for sickle cell at WPCT.
- WPCT should commission a sector strategy for haemoglobinopathies (possibly linking into the PBC cluster groups). The PCT must involve the community to ensure it is fully aware of need – the Sickle Cell support group would be a good starting point.
- There may be an opportunity to make expectations around diversity and equalities more explicit within St Georges' SLA, in light of its apparent willingness to 'raise its game' in this area.

The Peer Review Team

Heather Blake

Assistant Director, Long Term Conditions and North Locality, Lambeth PCT

Heather's current role involves managing the services for a locality including GP contracts and community nursing teams, together with a range of specialist community nursing and therapy teams across the whole Borough. She also leads within the provider side of the PCT on developing services for people with long term conditions. This is her second NHS role, the first being as a manager of surgical services in a hospital Trust. Prior to joining the NHS she ran her own business for three years, and before that was an economist and policy adviser in the civil service.

Sheila D'Souza

Non-executive Director, Westminster PCT

Dr Sheila D'Souza is a bio-scientist by training with a long career in a major multinational company. She has a longstanding interest in healthcare. Prior to being appointed a Non-executive Director, she was a member of the Patient and Public Involvement (PPI) Forum for Westminster PCT and represented the PPI Forum on the Trust Board. She is also a Trustee of Westminster Advocacy Service for Senior Residents.

Steve Gulati

Director of HR and Organisational Development, Eastern Leicester PCT

Steve Gulati has 10 years experience of Human Resources and Organisational Development in the NHS, having worked in major acute teaching hospitals in London and Birmingham before moving to primary care. He has a specific interest in organisational development and the needs of BME leaders, and is currently working on a research project to determine the impact of participation in national equality and diversity programmes on organisational performance. Steve is a former policy advisor to the CIPD, and holds various appointments in the public sector in the West Midlands.

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.

Sally Hawkins

Thinking Partner, Wandsworth PCT

Sally Hawkins is an independent trainer and consultant. She was until recently a non executive director of Lewisham hospital trust board, and was previously on the board of a community health trust. Sally is also currently a council member of the GMC. Her career has spanned the public, voluntary and private sectors and she has considerable experience (in the fields of health, social services, criminal justice and advice services) of implementing changes in practice in order to tackle discrimination and exclusion.

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.

Barry Mussenden

Joint Branch Head at the Department of Health Equality and Human Rights Group, Department of Health

Barry has a shared lead on developing equality strategy within the Department and promoting equality in health and social care policy, service delivery and employment. Before joining the Department in 2000, Barry had a long history of working to deliver race equality at both service delivery and policy level, and has been involved in the Race for Health programme since its inception.

Antoinette Scott

Service Development Manager, Ealing PCT

Antoinette has worked in a variety of administrative roles, starting initially as a secretary and progressing to a senior management role in project management and service redesign and improvement in an acute hospital and now Ealing PCT. Antoinette's current projects involve the implementation and development of the local Choose and Book programme and setting up a community-based diabetes care service.

Claudette Webster

Associate Director of Access and Inclusion, Central Manchester PCT

Claudette has worked in the field of health and social care for the last 23 years. As a qualified social worker she specialised in supporting the needs of older people, championing older people's issues nationally and locally. She has worked in been operational and strategic roles within local government, latterly in the role as Assistant Director Older People service. Since returning to the NHS in 2003 Claudette has been driving forward the equalities agenda within primary care.

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.

Tendai Pasipanodya

Consultant, Shared Intelligence

Tendai has recently joined Shared Intelligence as a consultant, and has been working on research and global trends mapping. Tendai completed an MSc in Development Studies at the London School of Economics in 2005.