race for health

a transformational change programme

Shropshire County PCT Peer Review

21st/22nd March 2006

Outcome paper

Introduction

The Shropshire PCT (SCPCT) Peer Review took place on the 21st and 22nd of March, 2006.

The visiting team of Peers included representatives from Westminster, Bristol North, Eastern Leicester and Lambeth PCTs, and from Leicester City Council. The team also included the National Director of the Race for Health programme, Shropshire's Race for Health Thinking Partner and the learning programme coordinators, Shared Intelligence.

The review drew on presentations by and discussions with representatives from Shropshire PCT, including the PCT's Chief Executive, Director of Public Health, Race Equality leads, and other senior managers and representatives from the Race Equality Committee. The team also heard from some of the PCTs partners, including representatives from the Shropshire Partnership, the LSP's Equalities Forum, Shropshire County Council, Oswestry Borough Council and the local community and voluntary sector (a full list of participants can be found at Appendix 2). 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 the peer review team's findings and recommendations. It is drawn from discussions on the day, and as such will provide – much like the day itself – a set of 'informed reflections' of SCPCT's work in the area considered.

Theme and key questions for the Review

The thematic focus for the review was 'Partnership working around race equality in Shropshire'. Specific questions considered by the review team included:

- How effectively is SCPCT collaborating with its local partners around race equality, particularly through the mechanism of the Shropshire Partnership and its new Equalities Forum? What form has this taken, and what has it achieved?
- Does a sense of 'working in partnership' around race equality encompass leadership, managerial and operational staff within the organisations concerned? Is it perceived to be adding value by those involved?
- Specifically, how do PCT staff take up, and feed into, issues addressed by the partnership?
- Does the PCT have a clear sense of what it wants to achieve through the Equalities Forum, and how that will feed in to the Race for Health programme and the delivery of race equality?

SECTION ONE

Background and context

Shropshire County

Shropshire is a rural county with a population of around 289,000 people, most of whom live in market towns. Using population density as a measure of rurality, a third of the county's population live in sparse rural or dense rural areas. South Shropshire is the most rural locality, with 17% of its residents living in sparse rural areas and 33% in dense rural areas.

Shropshire is a predominantly affluent county – 119th of the 150 most affluent local authority areas in England – and only 2% of its population fall into the most deprived quintile in the country. The main pockets of deprivation are in Shrewsbury and Oswestry, with other smaller concentrations found elsewhere.

Car ownership in the county is very high at 87%, but transport and access are still important local issues.

Ethnicity

The proportion of the county's population from Black and Minority Ethnic (BME) groups has risen slightly from 0.7% in 1991 to 1.2% in 2001, but this figure remains significantly lower than the national average of 8.7%.

Chinese people are the largest single ethnic minority - making up approximately 0.4% of the population - followed by Mixed White, Black Caribbean and Indian populations. There are also a small number of Travellers sites in Shropshire.

As tends to be the case elsewhere, the age profile of the BME population is generally younger than the white population. However unlike national trends, the local ethnic population is not concentrated within deprived areas but dispersed across the county.

Shropshire also has a growing number of Eastern European residents, although there are no figures available for this group. At present, SCPCT relies on a combination of 2001 census data and 'soft' intelligence for ethnicity information, which leads to uncertainty around population numbers (e.g. foreign-born residents of 'white' ethnicity, such as Eastern Europeans, who may still have language or other needs).

Although three GP practices are commencing routine ethnic monitoring of patients shortly, this is voluntary; roll-out is not currently planned for the other 41 practices in Shropshire.

Shropshire County Primary Care Trust

Shropshire County Primary Care Trust (SCPCT) was established in 2002 and has a GP-registered population of around 284,000. SCPCT is a large provider trust and works closely with its sister organisation Telford and Wrekin PCT to provide a number of shared services, including Adult Mental Health services, Learning Disabilities services and Children's Services. The possibility of de-merging mental health into a separate provider trust is currently being explored.

A significant proportion of the PCT's revenue budget of £350m is spent on commissioning. Most of their services are commissioned from Shrewsbury and Telford Hospitals NHS Trust, and the Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust.

The PCT is also responsible for providing most of its own community health services and for supporting the development of primary care (General Practice, Dentistry, Pharmacy and Optometry). Additionally it has a responsibility to work closely with non NHS agencies such as Shropshire County and District councils, the Council for Voluntary Services and other local partners on issues relating to, and affecting the health of the people of Shropshire County.

The PCT has a staff of 2,373 employees, of whom 2.6% are from BME backgrounds - a proportion that is more than double that of the BME population in Shropshire, at 1.2%. Further, many BME staff are in senior clinical positions.

Key challenges for BME groups accessing health services

'A study into the needs of the people living and working in Shropshire', a report written by Aston Business School for the Community Council, found that BME communities faced three main barriers to accessing services in Shropshire:

- *Demography and geography*

  BME residents face the dual challenge of low population concentrations and the often significant distances between services and their users, which is typical of rural settings. The first challenge is a barrier to the development of BME specific services, while the second introduces an additional barrier to accessing either these or mainstream services.

- *Lack of language support*

  A lack of language support for BME people was frequently cited as a barrier to accessing services in Shropshire. This includes the ability to understand the processes of public sector providers – in education and health care in particular.

- *Reluctance to seek support*

  Victims of racial harassment and racially aggravated crime are reluctant to seek help and thus draw attention to themselves.

One example of how these barriers may have impacted on BME health can be seen in emergency admission rates to hospital; admissions for people from BME groups are 1.4 times higher than for the 'white' population and significantly higher than the county average.

SCPCT suggested that a key difficulty in better understanding or accessing BME people in Shropshire is the dearth of formal representatives or groups. PCT staff explained that rather than actual 'communities', the BME population consists largely of dispersed individuals and families. Because of this, the PCT argued that it was difficult to consult BME people on their needs and views, and - where they could consult - that the numbers were too small to extrapolate from.

An exception to the lack of formal groups is the local Bangladeshi community, which has set up a Bangladeshi Welfare Association that the PCT works with. However SCPCT acknowledged that engagement with communities 'by proxy' also has limitations.

Working in partnership around race equality

SCPCT believes that partnership working is fundamental to tackling health inequalities, including issues around race equality. The PCT aims to work with the Local Strategic Partnership, District Councils and County Council, other statutory agencies, service providers and members of the local voluntary and community sector (VCS) to progress this work. With such small numbers of BME people living in Shropshire and limited resources to work with, a shared approach should make partners' efforts more effective.

SCPCT jointly commissions health and social care services with the county council, through integrated teams. The review team heard that the promotion of race equality is a contractual obligation for all commissioned services, and that race equality issues are considered by service planning groups. Joint training has been run in diversity cultural awareness, which has proven very popular with staff. SCPCT is also trying to work up a policy on racial harassment in mental health.

SCPCT sees its participation in Race for Health as another way of developing its work in this area, through exposure to new ideas, joint learning and peer support.

Race Equality Committee

The Race Equality Committee (REC) is a sub-committee of the Primary Care Trust Board and is responsible for promoting race equality within the PCT's three core functions; the direct provision of services, service commissioning and employment practices.

The REC also ensures that SCPCT complies with the required standards set out in the Race Relations Amendment Act (200O). This calls for public bodies to advance race equality by eliminating unlawful discrimination, promoting equality of opportunity, and promoting good relations between people of different racial groups. The PCT sees this duty as a key area for collaboration with partners.

The REC is chaired by a non-executive director of the PCT Board and the membership of the committee reflects the PCT's three core functions. Members include an executive director and representatives from across the PCT, as well as representatives from partner organisations (e.g. the Acute Trust and County Council), and the VCS.

Shropshire Partnership

Shropshire Partnership was formed in 1997 and formally became the county's Local Strategic Partnership (LSP) in 2002. It brings together 20 key local agencies and 70 other organisations - including regional and local government and representatives of the VCS - in order to foster joint action and attract inward investment to the county. Shropshire Partnership's vision statement is 'to improve the quality of life in Shropshire', and its remit covers the economic, social and environmental well-being of communities, and sustainable development.

As well as a management group, the LSP has a Public Services Board which brings together local authority Chief Executives and political leaders with statutory agencies. SCPCT has representatives on both of these boards.

Shropshire Partnership is unique in bringing its district community strategies together into an integrated county-wide Community Strategy, which ties in with the Local Area Agreement (LAA). SCPCT has worked closely with Shropshire Partnership to develop the Community Strategy and, during the next phase, will be a key delivery partner. The PCT and its LSP partners collaborate around the following areas:

- reducing health inequalities
- promoting healthy living
- reducing obesity
- encouraging and helping people to quit smoking
- promoting sexual health
- promoting mental health and well-being
- reducing alcohol related harm and encouraging sensible drinking

The review team heard that Shropshire is not yet 'a welcoming place for all'. 'Promoting Diversity and Social Inclusion' was identified as a top priority in the Shropshire Partnership Strategy (2005/10) and the Countywide Strategy (2005/10). The LSP agreed the establishment and funding of an Equalities Forum and a diversity officer post, and partners committed to a shared work programme.

The Equalities Forum

The Equalities Forum was established by the Shropshire Partnership in early 2005, but its membership is wider than the LSP itself. Forum members are mainly from the community and voluntary sector, including 40+ groups with an equality focus, as well as local 'interested individuals'.

The Forum's objective is to eliminate all forms of unfair treatment and discrimination in Shropshire and ensure that all services are equally accessible to potential users, regardless of race, gender, sexual orientation or other status. It also aims to represent the views of Shropshire's under-represented and excluded groups, including BME communities, drawing on members' informal networks.

The Equalities Forum:

- implements Shropshire Partnership's policy statement on diversity and equality;
- develops and delivers an annual diversity and equality work programme – e.g. establishing a hotline for reporting racist incidents, or recent research into attitudes toward gay and lesbian people in the local tourism industry;
- meets four times a year to discuss local and regional issues;
- obtains financial support from partners; and
- presents modest equalities awards to local groups in the area.

SECTION TWO

Findings and Recommendations

The peer review team received presentations from representatives of SCPCT and the LSP, Shropshire Partnership. The team also broke up into smaller groups and had the opportunity to meet some of the PCT's key partners. The findings and recommendations that came out of all of these meetings are summarised in this section.

The peer review team was impressed by:

Commitment

- The review team was impressed by SCPCT's clear commitment to, and prioritisation of the race equality agenda despite the small size of Shropshire's BME population.
- Further, the PCT shows great enthusiasm and bravery in pushing ahead with this work in the face of some resistance both internally and externally, and the review team welcomed the leadership's assertive approach. SCPCT should continue its practice of visiting other rural PCTs to share learning and ideas on tackling racial equality in a rural context.
- The review team supports the recent shift in lead responsibility for race equality to the Public Health department, which should enable better integration of this work with the latter's research and outreach functions.

Practical steps towards race equality

- The review team found some examples of practical, and importantly, visible steps that the PCT and its partners had taken to meet the needs of BME communities, including:
  - Establishment of the Race Equality Committee, which reports directly to the PCT Board and helps to maintain a race equality focus across the organisation
  - Progress on reviewing the PCT's commissioning arrangements, ensuring that equalities and diversity are 'built in' at an early stage
  - Introducing compulsory training courses on diversity and cultural awareness (not just discrimination) for PCT staff
  - Sourcing interpretation services for non-English speakers, and publicising these to GPs, service providers and patients. The PCT should continue to ensure that BME residents in Shropshire are aware of any such specialist services available
  - Securing the introduction of women-only swimming facilities at a local pool, following requests from BME residents
  - Setting up a hotline for the reporting of racist incidents in Shropshire; and working on a multi-agency strategy for addressing hate crime (e.g. outreach in schools)
  - Family Support/Sure Start Workers sourcing health information in Bengali, to meet a need identified at the frontline. These materials are made available at community events (e.g. Eid celebrations)
  - Moves to prepare a policy on racial harassment within mental health

Collection of data and intelligence

- A considerable amount of intelligence on local BME populations is held by frontline staff, and this is transferred informally between teams.
- An ethnic monitoring pilot project involving three local GP surgeries is planned, funded by SCPCT. This is an encouraging development, although participation is voluntary and relatively small-scale.
- The PCT has recently commissioned research into the local Chinese community. Although the

review team did not have the opportunity to view the survey findings, it encourages the PCT to continue deepening its knowledge of its BME population, and to ensure that the results feed into its service commissioning (see below).

Partnership working

- Team members heard from Oswestry Borough Council that there is good partnership working between the council and SCPCT at all levels, from the top of the organisation to the frontline. SCPCT staff maintain excellent working relationships with their counterparts at OBC, led by the PCT's Local Area Manager.
- SCPCT is clearly respected by its partners and has demonstrated that it is willing to take a proactive leadership role in partnerships – for example, the PCT Local Area Manager chairs the Crime and Disorder Reduction Partnership in Oswestry.
- The value of equalities and diversity work is championed by SCPCT in its relationships with the borough councils; the PCT is said not to be deterred by a lack of enthusiasm in some quarters.
- The PCT should take advantage of the opportunity offered by the negotiation of the Local Area Agreement (LAA) in Shropshire to work out joint policies with the local authorities and other statutory partners. This is also a good way for the PCT to make its partnership work more action-focused and target-based.
- The review team saw examples of good partnership working such as:
  - Integrated service planning and delivery across health and social care, in partnership with the County Council. Formal joint appointments – e.g. in public health, workforce and commissioning – form a strong foundation on which to build a substantive partnership
  - SCPCT works closely with some of the borough councils to support the Sure Start service, and on other initiatives (e.g. the 'Warmth in Focus' heating scheme, which draws on intelligence from PCT Health Visitors)
  - Partnering with specialist providers such as Destiny Healthcare for recruitment of carers, which has positively impacted on SCPCT's race equality work by boosting the number of BME carers working for the PCT
  - A partnership approach to the creation of the Children's Trust, including comprehensive input from the community and voluntary sector
  - The use of 'second homes' income (from council tax) to fund partnerships and the Equalities Forum - a positive and imaginative solution
  - The Health 4 Oswestry (H40) consultation initiative took an innovative approach to identifying health needs in Oswestry, including outreach through doctor's surgeries. SCPCT should encourage greater learning between partners, with successful techniques such as this being replicated and lessons shared
  - At the district/borough level, consultation events 'Lets Talk' and the 'Shropshire Debate' have allowed local people to raise issues with the LSP

Tackling Racism in Shropshire

- SCPCT has a zero tolerance policy for racism and other forms of discrimination. It has responded promptly and forcefully when required.
- Anecdotal evidence as well as the incidence of hate crimes suggests there is a continuing need to tackle racism in Shropshire. SCPCT should continue to pro-actively support any efforts to combat racism in the county, such as its work with Anti-Racist Alliance. One way to do this would be through a more active engagement with Shrewsbury Action Against Racism at the practitioner level.
- The review team welcomes the PCT's support for cultural events as a positive step towards encouraging community cohesion, and commends its interest in growing an annual 'equalities

event' based around existing cultural celebrations. For example, 3000 people attended the Runga-Rung cultural festival held by the Bangladeshi community and supported by the Equalities Forum. Such events are an important step in encouraging greater cross-cultural understanding and discouraging racism.

Areas for further development

Understanding the BME population and their health needs

- Team members were not completely convinced of the PCT's grasp of the size, characteristics and any specific needs of the BME population in Shropshire. For example, it seemed that new migrants from Eastern Europe are not included in the PCT's definition of BME groups, and this may be a significant omission in certain areas of Shropshire. The team recommends that the PCT undertakes a more detailed analysis of the 'White' ethnic group, as this classification may still include minority groups with specific needs (e.g. Travellers).
- Although the health and access needs for BME people may not always be dissimilar from mainstream users or other excluded groups, it wasn't clear whether this was known for certain. There is a need to more clearly define the "problem" before solutions can be found – e.g. is it poor access to mainstream services, lack of culturally appropriate services, racism and discrimination, lifestyle as a factor in disease, or other issues?
- The PCT may need to:
  - draw on existing research into ethnicity, culture and health; e.g. as a factor in predisposal toward disease;
  - actively investigate when BME people's take-up of services is low (or take-up of acute services is high); and
  - take a more proactive approach to gathering BME users' feedback on their experiences of health care.

Collection of data and intelligence

- Overall, the review team believes systematic collection of ethnicity data from primary care is a key area for further development for SCPCT, as it can underpin more advanced needs analysis and work on customised prevention and treatment.
- While some informal intelligence is filtering through from frontline staff, this should not be seen as an alternative to either routine ethnic monitoring or baseline research. The ethnic monitoring project currently being trialled in three GP surgeries should be considered for roll-out more widely.
- The team were not able to find any formal mechanisms for collection, analysis and dissemination of the local intelligence that is available, either within SCPCT or between the PCT and its partners.
- As they are a valuable source of information, there is a need to find ways to access groups that do not come into contact with frontline staff.
- The PCT should consider sharing or pooling resources with its partners (e.g. local authorities, schools, the Police, the business sector and the VCS) to gather both hard data and local intelligence on BME groups in Shropshire. There is an increasing duty on statutory bodies to promote equality, and good ethnicity information will be equally useful for all. Further, by tapping into a wider range of sources, SCPCT can ensure there is no over-reliance on any single source and that anecdotal evidence is more likely to be substantiated.
- As the numbers of BME people are small overall, the team accepts there may be barriers to conventional research methods; however this could also work in favour of alternative methods, and more systematic use of existing informal networks. The experience of other rural counties might be valuable to draw on here.

Community engagement

- While engagement with BME people is easier when there are formal structures set up (as is the case for the Bangladeshi community) the PCT must make sure it also engages with communities where such structures do not exist, as is the case with the Chinese population.
- Conversely, in BME communities where formal structures do exist, the PCT must take care to ensure that it does not engage exclusively through these - unless it is confident that they are completely representative of those communities. SCPCT will almost always have to further engage, or engage differently with people who may otherwise not be heard.

Commissioning and service delivery

- The review team did not see much evidence that service delivery was being customised to meet specific BME needs, although uncertainty about those needs combined with small populations will be barriers to achieving this. However, SCPCT and individual staff should not automatically assume all their work is inclusive because of a commitment to race equality.
- Consequently, the mechanisms which link the findings from data collection and local intelligence to the commissioning process will require further strengthening, especially as the PCT develops its understanding of need. The review team encourages the PCT to take a more proactive approach to incorporating its increasing knowledge about race equality in health into service commissioning - and ultimately into delivery. Public Health, now lead on race equality within SCPCT, must work very closely with the commissioning function.
- SCPCT is in a strong position to lead the way within Shropshire Partnership and, through its commissioning role, to raise its expectations of its own providers around race equality.

Partnership working

- The review team sees an opportunity for SCPCT to improve partnership working with its partners in the VCS, above and beyond shared membership in existing groups (e.g. the Equalities Forum). By moving beyond meetings to actually working with specific members of this sector who are engaged with BME groups, the PCT can further develop its understanding of, and access to BME communities.
- Without this level of cooperation, there is a danger that partners may undermine or duplicate each other's work, as was the case in the parallel bids sent to the New Opportunities Fund by VCS groups and the PCT.
- However, more substantive engagement may have resource implications for VCS representatives, which SCPCT may need to address to ensure the arrangement is mutually beneficial.
- There appears to be little private sector involvement in Shropshire Partnership, despite the considerable potential influence of this group. SCPCT and its partners may be able to further their race equality work in Shropshire through a more dynamic partnership with this sector. For example, some members of the business community are keen to encourage more Asian business-people to set up in Shropshire.
- The private sector could also help SCPCT and its partners to fill gaps in their knowledge of BME populations, as some employers tend to have higher numbers of BME staff (e.g. Polish employees working in light industry).

Overall, the review team were impressed by the commitment shown by SCPCT to achieving race equality in Shropshire. The PCT is providing sound practical examples of good practice in race equality in a rural setting, and the review team encourages the PCT and its staff to continue to take this work forward.

APPENDIX ONE

List of recommendations
(Taken from Section Two)

Understanding the BME population and their health needs

1. There is a need to more clearly define the "problem" before solutions can be found – is it poor access to mainstream services, lack of culturally appropriate services, racism and discrimination, lifestyle as a factor in disease, or other issues?

   The PCT may need to:
   - draw on existing research into ethnicity, culture and health; e.g. as a factor in predisposal toward disease;
   - actively investigate when BME people's take-up of services is low (or take-up of acute services is high); and
   - take a more proactive approach to gathering BME users' feedback on their experiences of health care.

2. The PCT should undertake a more detailed analysis of the 'White' ethnic group, as this classification may still include minority groups with specific needs (e.g. Travellers, Eastern European migrants).

3. The PCT should continue to ensure that BME residents in Shropshire are aware of any specialist services available (e.g. interpretation).

Collection of data and intelligence

4. Systematic collection of ethnicity data from primary care is a key area for further development for SCPCT. The ethnic monitoring project currently being trialled in three GP surgeries should be considered for roll-out more widely.

5. Formal mechanisms should be established for collection, analysis and dissemination of the local intelligence that is available, both within SCPCT and between the PCT and its partners.

6. The PCT should consider sharing or pooling resources with its partners (e.g. local authorities, schools, the Police, the business sector and the VCS) to gather both hard data and local intelligence on BME groups in Shropshire.

Commissioning

7. The mechanisms which link the findings from data collection and local intelligence to the commissioning process will require further strengthening, especially as the PCT develops its understanding of need. The review team encourages the PCT to take a more proactive approach to incorporating its increasing knowledge about race equality in health into service commissioning - and ultimately into delivery.

8. As the lead on race equality within SCPCT, the Public Health directorate must work very closely with the commissioning function.

Community engagement

9. While engagement with BME people is easier when there are formal structures set up (as is the case for the Bangladeshi community) the PCT must make sure it also engages with communities where such structures do not exist, as is the case with the Chinese population.

10. In BME communities where formal structures do exist, the PCT must take care to ensure that it does not engage exclusively through these - unless it is confident that they are completely representative of those communities. SCPCT will almost always have to further engage, or engage differently with people who may otherwise not be heard.

Partnership working

11. The PCT should take advantage of the opportunity offered by the negotiation of the Local Area Agreement (LAA) in Shropshire to work out joint policies with the local authorities and other statutory partners.

12. SCPCT should encourage greater learning between partners, with successful techniques such as the H40 consultation initiative being replicated and lessons shared.

13. The PCT can further develop its understanding of, and access to BME communities by moving beyond meetings to actually working with specific members of the VCS who are engaged with BME groups.

14. Similarly, SCPCT should continue to pro-actively support any efforts to combat racism in the county, such as its work with Anti-Racist Alliance. One way to do this would be through a more active engagement with Shrewsbury Action Against Racism at the practitioner level.

15. SCPCT is in a strong position to lead the way within Shropshire Partnership and, through its commissioning role, to raise its expectations of providers around race equality.

16. SCPCT and its partners may be able to further their race equality work in Shropshire through a more dynamic partnership with the private sector. The private sector could also help SCPCT and its partners to fill gaps in their knowledge of BME populations.

17. SCPCT should continue to visit other rural PCTs to share learning and ideas on tackling racial equality in a rural context.

APPENDIX TWO

The Peer Team

Carolyn Clifton
Chief Executive, Eastern Leicester

Carolyn Clifton joined the NHS in 1979. She is currently the Chief Executive of Eastern Leicester PCT and the Chair of the Specialised Commissioning Group for Leicestershire, Northamptonshire and Rutland, leading work within the SHA on equality and diversity. Carolyn was appointed Chief Executive of City Central Primary Care Group in Leicester between 1999 and 2001. She has previously had various roles in Acute and Mental Health services management in Leicester, Wolverhampton, Barnsley and Boston, Lincolnshire. She has also been based at Trent Regional Office, working on the implementation of national policy and particularly within the area of specialised services.

Monica Glover
Policy Officer, Chief Executive's Office, Leicester City Council

Monica's primary work is in community cohesion and equalities. She has a strong link with Eastern Leicester PCT in developing cohesion approaches and is currently leading the development of a Disability Equality Scheme for the city council. She has previously held a range of senior management roles in community and further education colleges. Her focus is on strategic planning and policy development through partnership.

Joe Hegarty
Chair, Westminster PCT

Joe has been Chair of Westminster PCT since October 2004, having previously been Vice-Chair of the PCT and before that a Non-executive Director of Kensington and Chelsea and Westminster Health Authority. Joe's background is in local government - as an officer with Surrey County Council and as a Councillor in Westminster. As well as his health interests Joe has been involved in the field of education as a Chair of Governors and currently chairs Westminster's Chairs and Governors' Forum. In both areas he has been involved in the development and implementation of equality strategies.

Arthur Keefe
Chair, Bristol North PCT

Arthur Keefe has spent nearly all his working life in Health and Social Care. He initially trained and worked as a social worker, and then taught social policy to health and social care staff at UWE for nearly 30 years. For 10 years, from 1989, he was an elected Councillor on Avon County Council and Bristol City Council, and was Chair of the Social Services Committee in Bristol until 1999. He was Chair of Phoenix NHS Trust for its final two years, and is currently Chair of the Sector Skills Council for Care and Development and a member of the General Social Care Council.

Ian Sesnan
Non-executive Director, Lambeth PCT

Ian Sesnan is Vice-Chair of Lambeth PCT and Chairs the Audit Committee as well as the Patient and Public Involvement Subgroup. He serves in the Performance Committee and Strategic Capital Group and leads for the Board on Sustainability. Ian is also a voluntary Trustee of Kings College Hospital Charitable Trust. He worked for Friends of the Earth for five years, and the Lambeth Council for 16 years in posts related to consumer affairs, safety and urban regeneration. He is now working as an independent consultant specialising in projects with a community or social focus.

Maggie Rust
Thinking Partner, Shropshire PCT

Maggie has extensive experience of strategy and policy development and partnership working. She has worked in a number of roles in the public and voluntary sectors including head of policy in a metropolitan council, director of a voluntary organisation and managing community and neighbourhood services. Maggie has recently facilitated self-assessments and peer reviews with both LSPs and PCTs and supported community planning and neighbourhood renewal activity. She is also involved in several national policy evaluations. She is thinking partner with Bristol and Shropshire PCTs.

Helen Hally
National 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.

Barry Mussenden
Joint Branch Head of 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.

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.