Patient and Carer Race Equality Framework

Proposal for an organisational competency framework for mental health

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

National Collaborating Centre for Mental Health

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Introduction

1. The Patient and Carer Race Equality Framework (PCREF) will provide an organisational competence tool around race equality in mental health, designed to improve health outcomes, social outcomes and patient/carer experience and satisfaction. This will include a standard of care that patients and carers should expect to receive, the organisational competences required to achieve this and a patient- and carer-rated tool for quality of care. The PCREF will provide information on what services should do to ensure that patient and carer race equality is achieved. The PCREF will fulfil the recommendation for a Patient and Carer Race Equality Standard[1] set out in the Crisp Commission's Old Problems, New Solutions report (2016).

[1] The term 'Patient and Carer Race Equality Framework' replaces 'Patient and Carer Race Equality Standard' but will fulfil the same recommendation. The term has been amended to more appropriately reflect the intentions of this work.

Aims of the PCREF

- To ensure equality of treatment access, and experiences and outcomes in mental health care regardless of race/ethnicity.
- To provide a developmental competence framework for services, which will guide them towards a system that provides equitable mental health care regardless of race/ethnicity;
  - this will include domains and indicators that services will use to show they have achieved a level of high-quality care (including evidence, patient and carer information, percentage of people accessing the service relative to the population, and so on).
- To develop a patient- and carer-rated tool, which will be a measure of the experience of mental health services by people from black, Asian and minority ethnic (BAME) populations. This will be embedded within the organisational competence framework and will be used to measure improvements over time specifically for those from BAME backgrounds.
- To provide a methodology for determining the percentage of people from a particular race or ethnicity that should be represented in services in proportion to the population.

Background

- The Old Problems, New Solutions report made a recommendation to identify a clear and measurable set of race equality standards for acute mental health services – the 'Patients and Carers Race Equality Standard', which they suggested should be developed to test whether the WRES is having the desired effect of improving services.

  - This was endorsed as part of the Five Year Forward View for Mental Health (2016), particularly in light of persistent inequalities in early intervention and crisis care, rates of detention, and lengths of stay in secure services since the end of the 5-year Delivering Race Equality (DRE) programme (2010).
  - In 2014, the Joint Commissioning Panel for Mental Health (2014) issued guidance on commissioning mental health services for BAME people, drawing on the findings and recommendations from the DRE. In response to the DRE and other guidance, some areas developed initiatives aimed at improving outcomes for BAME groups; however, these projects have not been sustained or were side-tracked, with BAME issues no longer being the focus of their work, e.g. The Revolving Door Project in Birmingham and Solihull Mental Health Foundation Trust, Community Development Workers.
  - The DRE was successful in raising awareness of race inequality issues in mental health and in encouraging the development of initiatives to support equality of access and outcome. However, these initiatives have not generally embedded in mainstream services and there has been insufficient improvement in outcomes for BAME people, particularly in equality of detentions under the Mental Health Act.

- A different approach to supporting the delivery of more equitable mental health services is required, including fundamental change in service organisation.
- Building on the aims and recommendations of the Crisp Commission report, the Five Year Forward View, the DRE, the Guidance from the Joint Commissioning Panel for Mental Health and the Workforce Race Equality Standard (WRES), we propose the development of an organisational competence framework (the PCREF) aimed at iteratively developing and embedding practices that will improve race equality in mental health and embed the changes into the fabric and structure of services. This will improve the quality of services and the experiences of BAME people who come into contact with them.
- Scoping work has been led by NHS England (NHSE) in collaboration with the National Collaborating Centre for Mental Health (NCCMH) as part of the Advancing Equalities in Mental Health programme, with co-production embedded in its design and delivery.
- The PCREF will build on and advance existing work in reducing race inequalities in mental health services, and is more than a standardising and benchmarking system. It will contain clear guidance that allows local solutions for local population needs, which, if followed, will result in systemic change and result in better experiences and outcomes for BAME people in contact with mental health services.

Recommendation 22: In 2016, NHS England and relevant partners should set out how they will ensure that standards are introduced for acute mental health care, with the expectation that care is provided in the least restrictive way and as close to home as possible. These plans should include specific actions to substantially reduce Mental Health Act detentions and ensure that the practice of sending people out of area for acute inpatient care as a result of local acute bed pressures is eliminated entirely by no later than 2020/21. Plans should also include specific action to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant overrepresentation of BAME and any other disadvantaged groups within detention rates. Plans for introduction of standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17.

Five Year Forward View for Mental Health (2016)

Proposal for the PCREF

Services in scope

- Integrated care systems and sustainability transformation partnerships, and all services included in these

Demographic groups

- People from black, Asian and minority ethnic (BAME) communities

Tools

- The Patient and Carer Experience Tool (to measure patient and carer experience), to be embedded within the:

    - Organisational Competence Framework for Mental Health (to support the development of systems of care delivery which enhance race equality in mental health)

- Methodology for determining the percentage of people of a race or ethnicity that should be proportionally represented in services

Considerations

The profound inequalities that exist for people from BAME communities in access to treatment, experiences of care and outcomes following care represent an overwhelming need for policy change to support effective local action:

- The consistent overrepresentation of black African and Caribbean people in detention is symptomatic of systematic failures to respond to the needs of this community, and they have not been reduced by numerous policy initiatives, including the 2010 Delivering Race Equality programme
- People from BAME communities are 40% more likely than white British people to come into contact with mental health services through the criminal justice system, rather than referral from GPs or talking therapies
- Black adults are more likely than adults in other ethnic groups to have been detained under a section of the Mental Health Act
- White British adults are more likely to receive treatment for mental health problems than adults in other ethnic groups (13.3% for white British adults versus 6.3% for black adults, who have the lowest treatment rate)
- Of adults in all ethnic groups, those from South Asia are least likely to be referred to specialist services – despite being frequent consulters of primary care.

Solution

The development of an organisational competence framework presents an opportunity to support organisations to operate differently, in response to the particular needs of BAME communities. It will result in net cost savings to the system through a reduction in direct health sector costs; improvement in productivity (costs of absenteeism, unemployment, lower performance at work, and so on) and reduction in intangible costs, such as pain, suffering and premature death.[2]

Findings from the interim report of the Independent Review of the Mental Health Act (2018) show that people from BAME communities have an especially high risk of being sectioned, with particular groups (such as black African and Caribbean communities) having poorer outcomes over time. The extent to which factors such as discrimination, poverty and social exclusion play a role in the over-representation of BAME people being detained under the Mental Health Act is unclear, despite the significant amount of research seeking to explain observed differences.

Based on consultation and focus-group research with participants from BAME communities, the report concludes that factors such as a lack of cultural awareness in staff and a need for culturally appropriate care, as well as structural factors which engender racism, stigma, stereotyping and increase the risk of overmedication may play a role in the differential experiences of BAME communities. The development of an organisational competence framework provides an opportunity to address some of these factors and improve experiences.

[2] A Elias, Y Paradies. Estimating the mental health costs of racial discrimination. BMC Public Health. 2016;16:1205.

The Organisational Competence Framework for Mental Health (PCREF)

- The Patient and Carer Race Equality Framework (PCREF) will be an organisational competence framework that supports the Crisp Commission recommendation for a patient and carer race equality standard.
- Work led by the Mental Health Act Review African and Caribbean group (MHARAC) of the Independent Review of the Mental Health Act has focused on methods for addressing systemic injustices in relation to the experiences of people of African and African-Caribbean descent who receive treatment under the Mental Health Act.
- There is wide-ranging support for a framework that will hold local systems to account more robustly, to improve overall outcomes for black people and people from other minority ethnic groups, bringing the perspective of patients and carers to the centre of service-led quality improvement agendas – in direct correlation to the aims of the recommended patient and carer race equality standard.
- Use of the PCREF has the potential to lead to an enhancement of relationships between services and communities, enabling services to re-align structural processes such that they are better able to achieve equity of outcomes for BAME people. This will build trust that encourages people with mental health needs to present earlier and avert crisis. There are then likely to be fewer admissions and detentions under the Mental Health Act, bringing clinical, social and economic benefits in both the short and long term.

What is the PCREF?

1. A **practical tool that supports service improvement by helping organisations understand what steps to take, and it will incentivise and measure attainment against set levels of service** – it will function as more than a benchmarking model such as the WRES.
1. Aids the delivery of improved care using a practical **quality improvement approach** that is tailored to each local area.
2. **Supports organisations to fulfil largely existing obligations under the Equality Act** (such as Public Sector Equality Duty) at no additional burden to organisations, and supports them to collect and use data efficiently and effectively.
3. It can be utilised beyond the health system. A similar methodology can be used by other public sector bodies, e.g. the Police Service, Ambulance Trusts, Local Government to support their obligations under the Equality Act 2010.
4. Development of the PCREF will include an appraisal of the aspects of mental health services most relevant to BAME people, using existing data and taking into account feedback from engagement with relevant service user groups and stakeholder organisations. Feedback from the MHARAC and the Advancing Mental Health Equalities groups of the Independent Mental Health Act Review will be key in determining the areas to focus on.
5. A patient and carer experience tool will be developed. The best patient and carer experience measures will be determined and, if needed, modified; if inadequate, new

experience measures will be developed for use in BAME populations to support the benchmarking of services. Thus there will be a variety of ways in which improvement will be measured, including the structure and content of the PCREF which will be constructed in a way that moving up through the levels will in and of itself be a measure of improvement.

6. An outline of an example organisational competence framework is in Appendix A. It shows how a provider or commissioner of services can develop their offer over time to enhance the mental health care delivered to people from BAME backgrounds. This can be done in an incremental way that follows an iterative process, allowing cultural change to be embedded into the mental health care delivery system. An incentive for change in the example is the awarding of a charter mark, but different drivers and levers can be utilised to facilitate implementation of the PCREF, e.g. showcasing and publication of the services that fulfil Level 1 criteria or even additional funding.

How will it work?

1. An example organisational competence framework is outlined in Appendix A.
   - **Levels** of attainment contain **goals** that organisations can achieve, underpinning the duties of the Equality Act.
   - The **goals** focus on awareness, staff capability and training, data and monitoring, and service development.

2. Service providers will be **mandated** to develop and/or comply with a pre-developed framework, most likely via the **Equality Act**.

3. Each trust can work towards the goals by **responding to the needs of their individual population**, taking decisions on a local level about required actions.
   - A sum of money may be made available for areas to bid for, to support the development of, for example, substance misuse services that support the achievement of set goals.

4. It is expected that there will be a role for the Care Quality Commission (CQC) and/or other equivalent regulatory bodies to **monitor compliance and attainment on a national level**, with patient and carer representatives having an active role in the assessment.
   - This may require additional powers (and resource) to enable the CQC to pay attention to individual cases and undertake appropriate sanctions (possibly at individual ward-level).

5. A system of incentives, levers and drivers will be developed with NHSE and other stakeholders to facilitate adherence to and delivery of the PCREF.

Considerations for implementation

1. As part of the future development of the PCREF, further detailed modelling is required to understand the proposed level of incentive(s) and a detailed assessment of costs. They would need to include cost implications of:

   - establishment of national programme of monitoring/reporting, including identifying key metrics and sources of data
   - development (and implementation) of training programme package
   - service development fund, for example substance misuse services, probably available via a bidding mechanism
   - recruitment of patients and carers for a CQC inspection panel
   - any other incentives, levers and drivers.

2. It is important to note that, particularly in the case of people of African and Caribbean descent, the PCREF has the **potential to reduce overall spend on treatment (by reducing the need for detention under the Mental Health Act) as well as limiting the impact of wider economic inactivity** by increasing the likelihood of earlier presentation, and improving engagement and adherence to clinical care.

How the PCREF will be developed

The NCCMH has a long history of successful guideline development. The proposed procedure for development of the PCREF is as follows:

- Policy and guideline review – around BAME mental healthcare delivery
- Evidence review:
  - around competence frameworks and how these are successfully embedded into organisational practice
  - around patient and carer experience measures, particularly for BAME people.
- Consultation/focus groups with experts by experience and professional experts
- Link with WRES developers regarding engagement with services and embedding new ways of working
- Link with MHARAC and AHME group from Independent MHA Review, to ensure aims align with their recommendations
- Link with regulators and other stakeholders who may influence adherence to the competency framework
- Develop/determine best patient and carer experience measure with support from Experts by experience and Service User Research Group at Institute of Psychiatry, Psychology and Neuroscience
- Develop statements around organisational competency to include in framework model
- Conduct a Delphi/nominal group technique (scientific method to achieve consensus) to determine competences most likely to be effective in bringing about organisational structural change.
- Write up the organisational competency framework (PCREF)

Future goals

- To propose year-long trials across England of the PCREF in a handful of pilot sites whose populations have different needs (for example Lambeth, where there is a large black population, and Birmingham, where there is a large South Asian population).
- From the trials, evidence can be gathered and used to refine the model before it is rolled out more widely.

Appendix A: Example organisational competence framework for race equality in mental health care

Below is an example of what a level-approach competence framework could look like. The example in this appendix includes five levels that could be achieved. Achievement of Level 1 would be associated with a charter mark which could be displayed by those organizations as a mark of quality. This would be akin to the Race Equality Charter mark awarded to higher education institutions and research institutes. Such approaches have been associated with change and improvement in organisational structure and culture. Organizations which have achieved Level 1 could be celebrated by NHS England and other ALBs such as the CQC could use the achievement against the OCF to assess the quality of the service provided. On the way to achieving level 1 and the Race Equality charter mark, the organization could display that they are at, for example, Level 3 and thus two years away from achieving the Charter mark. All organizations would be expected to be working towards and eventually achieve Level 1 and thus the Race Equality charter mark. The actual framework would be developed comprehensively, with engagement and consultation with relevant stakeholders. This appendix is intended to provide an example only.

(Note: this version uses a charter mark award scheme as a lever for change. Evidence of each criteria should be provided)

Level 1. Race Equality Charter mark awarded, renewed annually for 3 years, then renewed triennially

1. Evidence of **specific activities/processes** aimed at improving the mental health of people from BAME backgrounds, such as:

    - *interfaces with other agencies* to support and manage the mental health of people from BAME backgrounds, including third sector and primary care
    - *following agreed protocols with external agencies* such as primary care, detailing the action to be taken and referral paths to be followed (including abnormal results from physical investigations)
    - evidence of *co-produced, culturally appropriate services*
    - *substance-use services* that cater for the needs of people from BAME backgrounds
    - evidence that *culturally appropriate mental health interventions* are being developed and used
    - providing a *physical health screening clinic* that can be accessed by all people from BAME backgrounds who have a mental health diagnosis
    - running a *healthy lifestyle intervention programme* that includes individual as well as group activities

2. Evidence of organisational **awareness of mental health issues** in people from BAME backgrounds.

    - Board adopt this as a quality priority and there is evidence of regular oversight of services delivered to people from BAME backgrounds, their access to these services and outcomes in this group

- Board has a responsible officer who oversees matters for different BAME communities

3. Evidence that **interventions are in place to reduce unconscious bias** as well as **equality and diversity training** being mandatory
    - 75% of staff are trained

4. Evidence of **routine collection and monitoring of race, ethnicity and other equalities data** in local population demographics, service provision and delivery.
    - Maintaining a register of people receiving care by demographic (including ethnicity/race) and transparent information on how this data is used to improve delivery of care
    - Recording physical health screening data for people from BAME backgrounds

5. Evidence that a specific process is followed to ensure all people from BAME communities are **registered with a GP**

6. Consistently **good or above rating** on the patient and carer experience measure

Level 2. Less than one year from achieving the Charter mark

1. Evidence of **specific activities/processes** aimed at improving the mental health of people from BAME backgrounds, such as:
    - *interfaces with other agencies* to support and manage people from BAME backgrounds, including third sector and primary care
    - *following agreed protocols with external agencies* such as primary care, detailing the action to be taken and referral paths to be followed (including abnormal results from physical investigations)
    - evidence of *co-produced, culturally appropriate services*
    - *substance-use services* that cater for the needs of people from different BAME backgrounds
    - evidence that *culturally appropriate mental health interventions* are being developed and used

2. Evidence of organisational **awareness of mental health issues** in people from BAME backgrounds.
    - Board adopts this as a quality priority and there is evidence of regular oversight of services delivered to people from BAME backgrounds, their access to these services and outcomes in this group
    - Board has a responsible officer who oversees matters for people from BAME backgrounds

3. Evidence that **interventions are in place to reduce unconscious bias** as well as **equality and diversity training** being mandatory
    - 75% of staff are trained

4. Evidence of **routine collection and monitoring of race, ethnicity and other equalities data** in local population demographics, service provision and delivery.
    - Maintaining a register of proportion of people from BAME backgrounds
    - Recording physical health screening data for people from BAME backgrounds

5. Evidence that a specific process is followed to ensure all people from BAME backgrounds are **registered with a GP**.

6. Consistently **good or above rating** on the patient and carer experience measure

Level 3. Less than two years from achieving the Charter mark

1. Evidence of **specific activities/processes** aimed at improving the mental health of people from different BAME backgrounds, such as:
    - *interfaces with other agencies* to support and manage people from BAME backgrounds
    - evidence of *co-produced, culturally appropriate services*
    - *substance-use services* that cater for the needs of people from different BAME backgrounds

2. Evidence of organisational **awareness of mental health issues** in people from BAME backgrounds.
    - Board adopts this as a quality priority and there is evidence of regular oversight of services delivered to people from BAME backgrounds, their access to these services and outcomes in this group
    - Board has a responsible officer who oversees matters for BAME people

3. Evidence that **interventions are in place to reduce unconscious bias** as well as **equality and diversity training** being mandatory
    - 50% of staff are trained

4. Evidence of **routine collection and monitoring of race, ethnicity and other equalities data** in local population demographics, service provision and delivery.
    - Maintaining a register of proportion of people from BAME backgrounds
    - Recording physical health screening data for people from BAME backgrounds

5. Evidence that a specific process is followed to ensure all people from BAME backgrounds are **registered with a GP**.

6. **Satisfactory rating** on the patient and carer experience measure

Level 4. Eligible for Charter mark status

1. Evidence of organization's **awareness of mental health issues** in people from BAME backgrounds, such as a position statement, mission statement or board-level report

2. Evidence that the organization runs **training for staff in culturally competent practice**
   - evidence that **equality and diversity training** is mandatory for all staff (including managerial, administrative and support as well as clinical)

3. Evidence of **understanding of unconscious bias** and how this might affect decision-making.

4. Evidence of **routine collection monitoring of race and ethnicity and other equalities data** with respect to local population demographics and service provision and delivery.

5. Uses **patient and carer experience measure** to specifically measure quality of care for BAME people.

Level 5. Not eligible for Charter mark status

1. No evidence of awareness of the mental health issues in people from BAME backgrounds

2. No evidence that staff are trained in culturally competent practice.

3. No evidence of understanding of unconscious bias and how this might affect decision-making.

4. Provides no routine monitoring of race and ethnicity data in local population demographics, service provision and delivery.

5. Provides no routine culturally appropriate mental health interventions

6. No routine measurement of quality of care or experience for BAME people receiving mental health service.