BAMER Mental Health Community Development Service

Engagement Plan Winter 2018

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SECTION 1 BACKGROUND AND PURPOSE

1. Details of the service / provision - describe clearly the current situation

Service Outline

NHS Liverpool CCG currently commissions a Community Development Service (LCDS) to address inequalities in mental health experienced by BAMER communities and reduce barriers faced by members of BAMER communities who need to access support for mental health issues. LCDS is aimed predominately at people from BAMER communities with mental health issues, as well as the organisations, professionals and services who work with them and can provide support. People can self-refer to the service. They can also be referred by other agencies.

The service comprises the following key approaches:-

Representation & Advocacy
The service works to ensure that there is input from BAMER communities in the development of Mental Health services, as well as being a representative voice with health and social care organisations and other parts of the BAMER community. This aims to ensure that issues faced by BAMER groups and individuals in terms of their awareness, access and use of mental health services remains a priority on the agenda. The service also advocates on behalf of individuals with other agencies on a range of issues. Currently this is the only remaining advocacy service and it's independence from the service provider is vital to ensure effectiveness.

Signposting and Publicising
The service builds relationships with other agencies and groups, and provides effective signposting and publicity to improve BAMER communities' access to mental health services at the earliest possible stage. This includes making BAMER communities aware of the services that are available, and for the partnership to forge links with both statutory and non-statutory providers who can provide support.

Community Development
The service aims to identify community groups, organisations and champions working in this area and provides support, publicity and explores ways to ensure they are

sustainable in the long-term. Encouraging proactive action within BAMER communities is one way of ensuring this sustainability in the long-term.

Training and Education

The service aims to support people with mental health issues, as well as the professionals and individuals working with them, ensuring they are aware of the challenges and issues they face. This includes specific cultural awareness of the issues for BAMER communities as well as specific support around mental health and wellbeing. Mentoring and Support can be provided, as well as learning from what works.

Resources

The service costs c.£300,000 per annum and supports the following Whole Time Equivalent (WTE) staff resources:-

4 WTE Community Development Workers and 0.5 WTE Team Manager - Mersey Care

1 WTE Advocacy worker and 0.5 Administrator – Mary Seacole House

Outcomes

Monitoring for the period between December 2016 until November 2017 reported that the service

- offered 20 cultural awareness training sessions where189 individuals working in organisations supporting people with mental health were trained on cultural competence. 97% of attendees at the sessions indicated an improved level of knowledge and understanding of the topic following delivery. They reported increased confidence in working with BAMER service users in an appropriate way.
- supported and facilitated 36 community events;
- attended 136 meetings on behalf of service users;
- participated in 17 consultation events to represent BAMER communities.
- submitted 27 differing reports to groups and meetings for consideration.
- attended neighbourhood meetings, statutory provider meetings, BAMER faith leader meetings.
- established a service user forum so that users of mental health services can discuss their experiences, both good and bad, contributing to organisational learning and improvement.
- 327 individuals were signposted to other organisations for support.
- 56 individuals were directly supported as a result of the interventions.

Service Context

The LCDS contract is delivered as a partnership between Merseycare, PSS and Mary Seacole House. The service was commissioned from August 2015 following a competitive procurement exercise. A 3 year contract was awarded with a planned finish date of July 31st 2018 which has been extended until 31st March 2019.

In general people from Black and Minority Ethnic (BAMER) communities are:

- More likely to be diagnosed with mental health problems
- More likely to be diagnosed and admitted to hospital
- More likely to experience a poor outcome from their treatment
- More likely to disengage from mainstream mental health services, leading to social exclusion and deterioration in their mental health.

People from African Caribbean communities continue to be over-represented in mental health act assessments and compulsory admissions to hospitals.

The Joint Commissioning Panel for Mental Health (co-chaired by the RCGP/RCPsych), includes, within ten key recommendations the following relevant recommendations;

- Regardless of their ethnic background, everyone who uses a mental health service (or cares for someone who does) should have equitable access to effective interventions, and equitable experiences and outcomes. Commissioners have a legal duty to ensure this.

- Every commissioner should address ethnic inequalities in mental health. Commissioners need to fully understand the mental health needs of BAMER communities, and their experience of the local mental health system.

- There should be targeted investment in public mental health interventions for BAMER communities.

- From the outset, commissioners should involve service users, carers as well as members of local BAMER communities in the commissioning process. These individuals should be key in establishing the strategic direction and monitoring of mental health care and service outcomes.

- To create more accessible, broader, and flexible care pathways, commissioners should integrate services across the voluntary, community, social care and health sectors

- Every mental health service should be culturally capable and able to address the diverse needs of a multi-cultural population through effective and appropriate forms of assessment and interventions.

2. **What is being considered**? e.g. Policy? Service redesign? Patient information? Change of service? Change of service location/access? Removal of service? Change of provider? Define what is in scope and what is out of the scope of the engagement.

A review of the service specification, outcomes and monitoring framework is proposed. It is also proposed that from 1st April 2019 the service will be built in to LCCGs overarching contract with Mersey Care, rather than exist as a separate contract. Consideration will need to be given to the independence of the advocacy service.

Regarding the specification the proposal is to link the service specifically into the following areas of One Liverpool Strategy development –

- Meeting new targets for Improving Access to Psychological Therapies (IAPT) and for Early Intervention in Phychosis for BAMER communities.
- Linking Voluntary Community and Social Enterprise (VCSE) services to GP neighbourhood planning.
- Expanding the reach so that barriers face by BAMER communities are addressed at community/primary care level.
- Linking effectively with LCC developments.

3. **Why is this being considered?** State what is the legitimate aim of the service change / redesign, e.g. Service improvement? End of contract? In response to an issue? Value/efficiency? Providing patient choice? Public feedback? If it is responding to patient or other input please list who, how and when the issues came to light.

The service is reaching the end of contract period, however the need in the community and the statutory commitments of LCCG to address inequalities experienced in BAMER mental health remain.

It is intended that revisions to the specification and monitoring frameworks will enhance service delivery and outcomes in future.

The proposal to include the service within Merseycare's overall contract for local NHS services is intended to support continuity and sustainability.

4. **What is the benefit to the patient/public that is expected from the change**? How does this respond to JSNA or other needs/opportunities? What options for improvement have been considered? What is the evidence for the approach?

The aim of the service has been to reduce barriers faced by members of BME communities when seeking support with mental distress.

It is intended that BAMER community members will experience improvements in access to effective mental health interventions and mental health professionals will have increased knowledge and skills for effectively supporting people from BAMER communities and addressing mental health issues appropriately to patient need.

5. **What are you trying to achieve by engaging with people - what are the engagement objectives**? Informing those affected of a determined change? Influencing the change itself? Understanding how to address equalities issues? Be clear about what people can influence. Can the process / plans change as a result of the feedback and if so how much?

a) Understand the views of BAMER communities in Liverpool regarding Mental Health Services
b) Understand the experiences of BAMER community members in getting mental health support

c) Understand experiences of BAMER community members and organisations of the CDS service.
d) Understand the needs and experiences of BAMER communities regarding advocacy services.
e) Understand BAMER community members needs in getting support for children's mental health
f) Involve BAMER community members in revising the service specification and monitoring framework
g) Understand how to ensure the CDS services connect effectively with VCSE organisations
h) Understand if and how VCSE organisations can contribute to improving mental health among BAMER communities

6. **Who is involved in planning the engagement and what are their roles?** Is there an ongoing interest group involved? Clinicians, other CCG's, voluntary sector, etc. (NB ask engagement re volunteers to get input as early as possible in process).

LCCG Engagement Team and Mental Health Team, LCCG PPEEG.

7. **What has the governance route been for this proposal?** Which committees has the proposal been to, what decisions have been made etc?

In June 2018 LCCG Finance, Procurement and Contracts Committee agreed to extend the existing contract and following the engagement, the Committee will decide on the approach from 1st April 2019.

8. **What patient insight/research/experience data is there already available?** Have patients been involved so far? Or in the last year? What does this insight tell us? Are there relevant patient groups or other networks that exist – e.g. Breathe Easy. What evidence regarding equality issues exists?

In 2014 as part of re-commissioning the service engagement activities took place and produced a report with the following recommendations:-
- Leadership by mental health services is required to raise cultural awareness and responsiveness in their own services
- Sustained funding for bespoke BME services such as community development and advocacy should be established and built upon
- BME services should be balanced and impartial
- BME services should be embedded in the communities they serve, but seen as impartial and independent across the range of cultures, backgrounds and identities that come under the heading "BME"
- BME services should be influential at a strategic level to ensure that community priorities inform the future development of services
- Any service should take a family orientated approach, and make sure that the needs of BME women and their children are taken into account
- Dedicated support for Refugees and Asylum Seekers is required to mitigate against the negative impact of their involvement in the asylum process

- Advocacy is needed to ensure that individuals can realise their rights when interacting with public services
- Any service should take a holistic and person centred approach recognising the impact of socio economic factors on mental health and the importance of practical advice, guidance and support to address these.
- Any service should recognise the links between mental health and drug/alcohol use as a coping mechanism

The full report and other data relevant is available at www.liverpoolccg.nhs.uk
Where a dedicated page to this project is being created to support this engagement. During 2015/16 LCCG led a number of engagements with feedback from BAMER communities. These are also available from the website. Of particular importance to this project is the Alcohol services engagement where strong feedback regarding the need for bespoke services was provided.

SECTION 2   GAUGING IMPACT, SCALE AND RISK

9. Who is affected by what is being considered? Patient groups / Carers / Community members / Staff / Providers, Other professional stakeholders, Geography – e.g. location of service or access by a specific geographic community? Others? – List all internal and external audiences/stakeholders.
If staff are affected please also complete Section 3. The following questions relate to gauging impact, scale and risk for the public and patient engagement.

BAMER Community members/ Mental Health and BAMER support groups / Carers / VCSE organisations / MerseyCare LCDS Staff / PSS LCDS staff / Mary Seacole House LCDS staff / GP neighbourhoods across Liverpool, Liverpool City Council

10. Equality Pre-Assessment. Is the service specifically designed to serve people with one or more protected characteristic*? E.g. for deaf people. Review evidence regarding possible detriment to the following groups. List effects of this change against each of the groups with protected characteristics* and whether any may be discriminated against (must consider directly and indirectly) or particularly affected by the change? (Duty to prevent this – see below and p13 for definitions) Might any vulnerable groups be particularly affected /disadvantaged?

Is the service specifically to serve people with a protected characteristic?

YES

IF YES, PLEASE SAY HOW:

The aim of the service is to reduce barriers faced by members of BME communities when seeking support with mental distress.

11. In the assessment below indicate groups who may face particular impacts and if known what they may be. The engagement will explore issues with the relevant groups in order to understand any potential impacts and identify any mitigating

actions for implementation of the change. A full EIA will be conducted following engagement/consultation.

Extract from pre-engagement equality analysis (full document on website)

Protected Characteristic	Issue	Remedy/Mitigation
Age	10% of children in society suffer from mental health issues, when it comes to 'looked after children' this increases to 45% Key service issues for children are: • Helping children and young people stay mentally well (building resilience) tackling problems early to prevent them getting worse and taking action quickly if they do. • Making it easier to get support that works. • Care for the neediest young people. • Services doing things openly and honestly. • Having the right people in the right place at the right time in the workforce.	Ensure children can participate in the service of BAME background Ensure that 'looked after children' are included in the survey (consider specific events for this group – ensure BAME children are at the focus).
Disability	Eight out of 10 people with a disability weren't born with it. The vast majority become disabled through an injury, accident, heart attack, stroke, cancer or conditions like MS and motor neurone disease Government statistics show 47 per cent of people who were formerly receiving Disability Living Allowance (DLA) saw their support fall or stop altogether when they were reassessed for Personal Independent Payment (PIP). Of a total of 947,000 claimants who were reassessed in the year to October 2017, 22 per cent saw their support reduced, while a quarter were disallowed or withdrawn altogether — meaning 443,000 people will have had their claims reduced or removed. Physical disabilities: having a physical disability (and in particular where there is constant pain) can affect mental well being in addition to the frustration of society/environment not being designed to support/facilitate physical disabilities.	

(physical)	A large number of people with physical disabilities have also had great difficult in accessing or keeping disability focused benefits. This has resulted in depression and even suicide.	Ensure that BAME with disabilities are included in the consultation
(Mental health)	There will be BAME service users of current mental health service provision	Engage and consult with current service users (and past service users if possible)
Gender reassignment	Gender dysphoria, confusion/denial about gender, fears around transitioning, gender reassignment treatment delays and refusals, and social stigma increased suicide risk There is a high rate of suicidal ideation (84 per cent lifetime prevalence) and attempted suicide (48 per cent lifetime prevalence) within this group. A supportive environment for social transition and timely access to gender reassignment, for those who required it, emerged as key protective factors. Whilst this group remain a small percentage of society, Being BME and transgender is an even smaller percentage yet will have a double impact of being 'trans' and being 'black'.	Link with Trans groups to identify mental health needs (and issues) and what BAME Trans needs would look like. Include cohort in consultation
Marriage and Civil Partnership	N/A	
Pregnancy and maternity	King's College London found that one in four pregnant women (27%) were diagnosed with a mental health disorder when interviewed. Other studies have found that up to one in five women have a mental health disorder during or just after pregnancy[1]	Include 'pregnancy and maternity' in consultation programme. Did this group use any mental health services? How did they access it and what id they think the barriers where? (emotional /cultural issues

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[1] https://fullfact.org/health/mental-health-during-pregnancy/

Race		
		of being perceived as a 'bad mum'?)
Race	**African- Caribbean** African-Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups but are more likely to be diagnosed with severe mental illness. African-Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. However, most of the research in this area has been based on service use statistics. Some research suggests that the actual numbers of African-Caribbean people with schizophrenia is much lower than originally thought. African Caribbean people are also more likely to enter the mental health services via the courts or the police, rather than from primary care, which is the main route to treatment for most people. They are also more likely to be treated under a section of the Mental Health Act, are more likely to receive medication, rather than be offered talking treatments such as psychotherapy, and are over-represented in high and medium secure units and prisons. This may be because they are reluctant to engage with services, and so are much more ill when they do. It may also be that services use more coercive approaches to treatment.	Ensure African/Caribbean community fully engaged. As part of consultation process find out: • Service user experience • Perceptions of the community about Mental health care and where they would go • Types of mental health problems Develop links with domestic violence services and encourage participation in consultation by BAME service users.
	Asian The statistics on the numbers of Asian people in the United Kingdom with mental health problems are inconsistent, although it has been suggested that mental health problems are often unrecognised or not diagnosed in this ethnic group. Asian people have better rates of recovery from schizophrenia, which may be linked to the level of family support. Suicide is low among Asian men and older people, but high in young Asian women compared with other ethnic groups. Indian men have a high rate of alcohol-related problems. Research has suggested that Western approaches to mental health treatment are often	The will be a strong case for Equality Act 2010 schedule 9, work exceptions A person (A) does not contravene [the equality act] if A shows that having regard to [particular protected characteristics of an employee] if • Its an occupational requirement • Is a proportionate means of achieving a legitimate aim Consultation needs to capture any information that shows people are deterred from using the

	unsuitable and culturally inappropriate to the needs of Asian communities. Asian people tend to view the individual in a holistic way, as a physical, emotional, mental wellbeing Irish Irish people living in the UK have much higher hospital admission rates for mental health problems than other ethnic groups. In particular they have higher rates of depression and alcohol problems and are at greater risk of suicide. These higher rates may, in part, be caused by social disadvantage among Irish people in the UK, including poor housing and social isolation. Despite these high rates, the particular needs of Irish people are rarely taken into account in planning and delivering mental health services Latin American /Portuguese Eastern European BAME - Homeless Refugees (asylum seekers)	service because the service providers do not 'look like them' Ensure all minority groups are invited to consultation. Consider language barriers
Religion and belief	• Cultural beliefs compounded stigma and that services needed to be more aware of that. • There's some belief that people from some ethnic backgrounds have a stronger resistance to drugs, therefore may feel they're more likely to be prescribed higher doses of medication, • Some services aren't equipped for certain communities and the taboos they face. You need to understand where people come from to understand what they're facing[2]. Women and young girls from South Asian communities often carry a great sense of shame and the need to preserve their family's honour "The difficulty is that people, especially young [Asian] girls, can find it difficult to talk to their	

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[2] Heather Nelson, chief executive of the Black Health Initiative

	parents and family about their mental health problems."[3]	
Sex (M/F)	The 2014 Adult Psychiatric Morbidity Survey (APMS) found the prevalence of common mental health problems to vary significantly by ethnic group for women, but not for men. Non-British white women were the least likely to have a common mental health problem (15.6%), followed by white British women (20.9%) and black and black British women (29.3%).	Consider linking with domestic violence units/services to canvass BAME service users.
	Black adults were also found to have the lowest treatment rate of any ethnic group, at 6.2% (compared to 13.3% in the white British group).[3]	Ensure strong consultation with BAME women
	In contrast, a 2015 study by Stewart-Brown and colleagues found that those of African-Caribbean, Indian and Pakistani origin showed higher levels of mental wellbeing than other groups; this was found to be largely attributed to higher levels of wellbeing found among men.	Link with community groups and women's groups especially Asian women's community.
	A review published in 2015, exploring the association between ethnicity, mental health problems and socioeconomic status found people from black ethnic minority backgrounds to have a higher prevalence of psychosis compared with the white majority population. This effect was still observed after controlling for socioeconomic status.	
	Studies show that PTSD is higher in women of black ethnic origin and this association is related to the higher levels of sexual assaults that they experience; however, women of black ethnic origin are less likely to report or seek help for assaults or trauma.	
	Disproportionate rates of people from BAME populations have been detained under the Mental Health Act 1983. A 2016 UK study examining the Mental Health Act 2007 assessments found this to be disproportionality associated with higher rates of mental health conditions and poorer levels of social support, but not due to ethnicity.	
	In Northern Ireland, the suicide rate among male Irish Travellers is 6.6 times that of men in the general population. This group also continues to experience discrimination, with	

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[3] Marjorie Wallace, chief executive of SANE

	65% of people reporting that they would not accept an Irish Traveller as a close friend[4] Women and young girls from South Asian communities often carry a great sense of shame and the need to preserve their family's honour "The difficulty is that people, especially young girls, can find it difficult to talk to their parents and family about their mental health problems."[5]	
Sexual orientation	There is also evidence that sexual minorities suffer from anxiety disorders at higher rates and are more likely to abuse alcohol and drugs compared to heterosexual people. Challenges such as the stigma associated with sexual minorities, discrimination, family disapproval, social rejection, and violence are among the factors that can lead to mental health problems[6] Being Gay and being BAME adds to the cultural stigmatisation as often BAME cultures are not accepting of LGB+ lifestyles.	Include LGB groups in consultation.
Other	Ensure service such as Police/ Boarder - Migration Officers are included the consultation as well as other professionals.	

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12. **How many people are affected?** E.g. how many people currently use this service? Does it affect all over 16s or 2-3 people having a rare procedure or one neighbourhood population or the whole city?

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Approximately 600 people benefit directly from the service. A wider benefit can be assumed from reports written and meetings attended.

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[4] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-black-asian-and-minority-ethnic-groups

[5] Marjorie Wallace, chief executive of SANE

[6] https://www.psychologytoday.com/gb/blog/evidence-based-living/201702/mental-health-and-sexual-orientation-what-the-evidence-says

13. **Is there a change to both the service and the location involved**? If location change how will transport access be considered? Is a full accessibility assessment needed (available from Merseytravel - ask Sarah Dewar)

No

14. **Is the change proposed likely to elicit a variety of strong viewpoints**? If no describe how you have decided this, and if yes, describe in what way & by whom?

Mental health among BAMER communities remains a challenge and people will have strong viewpoints on this and the action being taken to tackle it. The model of delivery may also be of interest to those working in this sphere.

15. **What scale and proportion of engagement is appropriate?** Assess what level of engagement activity is appropriate.

    Please state the numbers of people/range of stakeholders, etc. should be engaged, and what % of those should be current users of the service? Do you need qualitative / quantitative data or both? Think through who is going to use the feedback and what they will be looking for.

    Significant changes will require approval at QSOC / GB level. Do LA safeguarding / scrutiny panels need to be involved? Reconfiguration requires NHSE involvement see guidance as p1. Please note here if this process is feeding into a wider service reconfiguration and forward this to lead for that service.

Engagement with BAMER community members, VCSEs and representatives is proposed rather than focusing on service beneficiaries whose feedback can be sought via the service. We would aim for 100+ responses and propose a mix of online and face to face engagement. We anticipate involving VCSEs in the process should the budget be available to do so, otherwise the engagement will be led directly by the CCG and will involve a community meeting as well as online information sharing and working through networks.

16. **Does this change present a minor, moderate or high risk to LCCG?** Please describe why? This helps determine if it goes to committee or GB etc. (both manager and engagement group complete this)

Moderate risk as the response of the different communities is not yet known and the issue is problematic for those concerned.

SECTION 3   STAFF ENGAGEMENT

17. **Which staff groups are affected by what is being considered? Are any volunteers affected?**

LCDS staff are affected.

18. **What are you trying to achieve by engaging with staff - what are the staff engagement objectives?** E.g. Informing those affected of a determined change? Influencing the change itself? Be clear about what people can influence. Can the process / plans change as a result of the feedback and if so how much? As staff bring a different perspective, these objectives are likely to be different to the objectives you set for the public and patient engagement

Staff will be asked for their reflections on service effectiveness and revisions to specification and monitoring frameworks.

19. **How do you plan to communicate with staff?**

Via the contract lead.

SECTION 4   INFORMATION AND COMMUNICATION

20. **What information is/needs to be available, and how will it be communicated?** Information should include (depending on specific details of engagement being undertaken): a summary; discussion of the issues; benefits of what is being considered for patients/public, and how this addresses health needs; relevant information already taken into account or known; stakeholder involvement; proposed timetable; and a clear description of how responses will be used. Depending on the stage of the work (i.e. whether this is a pre-consultation engagement or formal consultation) information might also cover: an outline of options considered; assessment of any known impact on different groups; assessment of risks of change; transition plans (if relevant); budgetary implications; contingency arrangements as appropriate; info on penalties for non-delivery and exit strategy; list of those being consulted.

Summary of key issues and what is being proposed. Dedicated page on CCG website (containing all relevant information and link to online questionnaire) and in a printable format (which can be translated if required).

21. **What are the key questions you are seeking views on?** These should relate to the objectives. Is it clear? Open not leading questions etc.

a)   Understand the mental health support needs of BAMER communities in Liverpool

b)   Understand the experiences of BAMER community members in getting mental health support

c)   Involve BAMER community members in revising the service specification and monitoring framework

d)   Understand how to ensure the services connects effectively with VCSE organisations

e)   Understand if and how VCSE organisations can contribute to improving mental health among BAMER communities

Key questions

What barriers are faced by people from BME communities when trying to access support with mental health issues

What helps people to overcome barriers when accessing mental health services

How best to support communities to identify their own needs?

How best to build links between communities and support services so they are more responsive to community voices?

How best to provide information to communities about their rights and entitlements so that they can make the most of what resources already exist to support them?

How important/effective is the role of advocacy?

How do we develop support for individuals?

22. **How will input and responses be sought?** - online? Face to face? Via a third party – either their communication channels or groups? Paper based? **Online survey and comments, event, promotion via the CCG's communications channels with primary care (email bulletin, intranet, direct email to practices). Briefing to be shared with social care & health select committee and other key stakeholders.**

23. **Capacity building.** Will any stakeholders need time/support to better understand the issues before they are able to input? How can this be built in to the process (links to information), How can ongoing engagement with those interested and involved be achieved? Data needs to be entered into corporate database and handled appropriately (e.g. consent for future use, electronic storage).

Briefings will be collated regarding the issues and inequalities, history of the service, progress and aims. Anyone who wishes to stay involved will be kept involved via the engagement team.

24. **Does this method/s exclude or adversely affect anyone?** Will anyone not be able to take part? e.g. if all on-line. May the engagement itself distress anyone with protected characteristics or any vulnerable groups e.g. someone affected by service/ bereavement. If so what support can be put in place?

Interpreters will be offered for events and translations made available for key languages and on request for others. Mixing engagement methods will enable participation and this will be monitored for any groups not engaged.

25. **Test the process** – e.g. if it is a survey, test it with someone who is not involved in the process, see if the language is clear on a poster etc. describe here how you will do this.

LCCG volunteers will assist in ensuring language is accessible.

SECTION 5   UNDERSTANDING AND USING INPUT RECEIVED

26. **How will responses be analysed?** Who is responsible for receiving info? Who is responsible for analysing responses and reporting on this? If major reconfiguration an independent analysis of findings is recommended. What process will be used for utilising feedback that wasn't expected – e.g. about a different programme area

LCCG will analyse responses and collate a report

27. **How will responses be used?** What are the governance routes this report will follow? i.e. which groups/committees will it be taken to? Will a group need to convene to review responses and decide how to incorporate? And who will document this? A report must be written which describes the engagement process and responses. Ensure equalities implications and responses from vulnerable groups and people with protected characteristics are recorded, action to address defined, included in specification, shared with relevant providers and that this process is transparently reflected and recorded in documentation and final reports.

Responses will be provided to the MH team to inform the revisions to service specification and monitoring frameworks. FPCC will approve final proposals.

28. **How will the responses to the engagement, and how they have been used by decision makers, be fed back to participants and wider community?**

They will be circulated to participants and relevant groups and published online.

29. **Timelines.** When do you need the responses in order to be able to analyse them, consider how to incorporate them and use them to change the final proposal? How long will the engagement process take to give everyone a fair chance to get involved? How will changes be followed through and shared with relevant partners/providers

Engagement reporting will be required late February to inform the contract development. .Conduct the engagement January/February 2019: Analyse response Feb 2019

Feed back to engagement participants / wider community / providers / others partners Mar 2019

SECTION 6   IMPACT - COMPLETE FOLLOWING ENGAGEMENT

30. **What were the main findings from the engagement?** List the key findings from the report of the engagement activity.

The public survey responses identified that 62% of respondents to this question found it hard or never got the help they needed and only 38% found it easy. The qualitative community engagement carried out by VCSE partners also identified that those who had sought help had found it difficult to get support. Many sought support from family and friends and in their community rather than from the NHS due to stigma/cultural issues and low knowledge/accessibility of mainstream services. In addition, BAMER community members reported often keeping mental health issues to themselves due to the sense that non BAMER professionals do not understand cultural issues and this can lead to difficulties and misdiagnosis. Often where help was sought from GPs, the experience was unsatisfactory leading to reluctance to persevere in getting help.

Engagement also found that many people didn't associate emotional issues with mental health, often identifying this as having a 'rough time', and feeling a reluctance to medicalise responses to life events and situations. It was noted that in particular, post-natal depression in women was often seen as just normal feelings after having a baby, meaning women don't seek help. Generally however, depression, anxiety and mental health as a whole were commonly not seen as medical mental health conditions to seek professional help for. Groups described low awareness of mental health conditions, especially around dementia. Several groups reported on the vulnerability of older people due to isolation and being even less likely to discuss their problems with others. A cultural / spiritual context was sometimes reported around episodes of mental ill health and psychosis which it was felt was/would not be understood in a medical context.

Of those who had received help, 40% described negative experiences, 33% were neutral or mixed and 25% were positive. Negative experiences were largely due to the following:-

- **38% described a lack of understanding among staff and/or feeling uncomfortable discussing these issues**
- **33% identified a language barrier in both finding services and getting appropriate care**
- **30% identified long wait times as a problem**
- **14% said they had difficulty knowing what services were available.**
- **15% of those having a negative experience also described the quality of service they received as poor in other ways**

In your experience what barriers have you encountered in getting help with your mental health?

Barrier	Percentage
Waiting times	51%
Stigma surrounding mental health	22%
NHS staff's lack of cultural awareness	26%
Not knowing what help/services are available	38%
Attitudes – eg racism/poor attitude of staff re mental…	20%
Language e.g. availability of interpreters in mental…	45%
Physical barriers: service location, opening times etc	34%
Services don't meet my needs/are inappropriate	22%

All of these issues were also identified in the VCSE engagement activity and the reports describing previous feedback.

Waiting lists for services were also identified as a major barrier by almost all the VCSE groups for both children's and adult's mental health services, for hospital admissions, counselling/CBT, crisis support, psychologists and for GP appointments. Brain Charity participants reported waiting a number of years for support for their children.

Language barriers were identified by all community groups. Lack of information about services in languages other than English was universally identified as the case and as preventing people from knowing what services are available and also having the confidence to request help and feel the service is inclusive.

Limited experience of interpreters being offered was identified among VCSE group participants, with many being unsure interpreters were available at all and relying on family members. Many described speaking English but not being confident to discuss complex mental health issues in their second language. **Experience of interpreters suggested the quality was inconsistent.**

Brevity of appointments and support was commonly cited.

Disability was noted by several groups as adding an additional barrier to accessing care.

Free text comments made in the survey regarding barriers included references to **difficulties for carers**:

Priorities for improvement fell into the following categories:-

Outreach, translation and interpretation, practical help with social / immigration issues and online resources.

There was low use of LCDS and high use of families and community group support. GPs were the first port of call but often felt to lack the time or specialist skills to provide support.

Feedback from VCSEs also highlighted difficulties with NHS services including LCDS.

The full engagement report of the findings is available at
www.liverpoolccg.nhs.uk/getinvolved

31. How has this influenced the proposal/plan? List what has been changed / added etc to take into account the public feedback. Link to any equalities findings and changes here too. If you couldn't address issues explain why.

The findings were incorporated into the new specification for LCDS, even though this happened prior to the full report being published.

LCDS were tasked with providing an action plan in response to the issues.

As a result of the feedback NHS Liverpool CCG has:-

• Amended the requirements of the service, that are set out in the specification (insert link to spec) including as follows:-

- There was a shift from stating specific interventions to listing a number of outcomes which were to be reported on

- The needs of older people and for asylum seekers and refugees were specifically referenced

- The need for a focussed steering group to include community leaders as well as commissioners was included

- The role of the service in raising issues affecting BAMER communities specifically in respect of the Trust's own mental health services was underscored in the new specification.

• Shared the report with Mersey Care NHS Foundation Trust as the provider of the service and the team managing and delivering the service.

• Raised via contract management and quality assurance structures of the CCG the need for a revised action plan, and intentions around taking the service forward in the months following the transfer of the contract.

• The Mersey Care NHS Foundation Trust was due to report back with an outline of how they intend to develop the service in the Spring of 2020, however this has been delayed by the outbreak of Covid-19

• Included scope for ongoing engagement on the issue in NHS Liverpool CCGs 2020/21 engagement plans

32. **Specifications and Delivery.** How will/have you built ongoing public and patient engagement/feedback / opportunities for volunteering, peer support etc..into the future of the plan/service etc. See LCCG [social value strategy])…How will people involved in the engagement be able to stay involved eg participate in procurement / monitoring etc?

LCCG has committed to an ongoing forum to discuss the issues bringing together providers and services users and VCSEs.

33. **Feedback.** Describe how you will/ have fedback to respondents and the wider community on the outcome of the engagement and how their involvement has been incorporated into final decision making. If you couldn't address issues you will need to explain why.

The report is published on [the CCG website] and circulated by email to known participants. It has also been sent to relevant partners and providers.

34. .**Governance.** Describe the final governance / decision making route for the process and confirm that engagement and equalities outputs were included in this.

The report will be considered by the PPEG in August, and the Patient and Public Voice Committee of CCG.

Engagement Group Meeting 21/11/18 and QSOC Meeting 4/12/18 Comments	Score *	Action	Date
Section 1 Background and Purpose	2		
Specification needs to be explicit regarding which BAMER communities (EG)		SD to relay to MH	Nov
Query-is over represented due to misdiagnosis or what factors? (EG)		SD obtained info& fed back to group	Dec
Advocacy part of service to be independent from Mersey Care and review of this to be considered separately as now only remaining advocacy service		SD updated plan	Dec
Section 2 Gauging Impact Scale and Risk	2		
Need data on current BME profile of MH services- all services including admissions and IAPT(EG)		SD to obtain	Dec
Section 3 Staff Engagement			
Section 4 Information AND Communication	2		
Support face to face meetings in communities and particularly with partnerships with VCSEs(EG)		SD try to secure budget	Dec
Section 5 - Understanding & Using Input Received	2		
Group commented that with the contract ending in March there is a presumption that the current provider would be continuing to deliver the service. (EG)		noted	
Total:	Medium risk		
Lay Member Comments			

* Scoring criteria:

    1 = Not clear needs a lot of further work

    2 = Some issues need more clarity

    3 = Clearly thought out and planned

I confirm that the engagement plan has been updated and reflects my comments and those of the engagement group and the considered level of risk

Signed……………………………………………………..

Ken Perry, Lay member NHS Liverpool CCG, Lead for Engagement.

Engagement and Equality Planning Process and Risk Assessment

Who is this document for? NHS Liverpool CCG staff, patients and volunteers.

Engagement Duties

LCCG wants and is legally required to involve patients and members of the public in developing policies, planning, designing and commissioning services and to demonstrate how their views have influenced decisions. Clinical Commissioning Groups have the following statutory duties in the Health and Social Care Act 2012 as regards engagement:-

- involving individuals in their own care and in having patient choice
- making arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) –

    a)   in the planning of the commissioning arrangements by the group,

    b)   in the development and consideration or proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals, or the range of health services available to them, and

    c)   in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an implementation of the decisions would (if made) have such an impact.

  - reporting on these activities annually

Citizen engagement is also one of the six characteristics of a sustainable health and care system outlined in Everyone Counts: Planning for patients 2014-2019, NHS England and is one of NHS England's five tests for major service change and reconfigurations.

This process helps enable LCCG to meet our duties and NHSE guidance on participation.

Equality Duty

The public sector Equality Duty (PSED) requires public bodies to have due regard to:-

• Eliminating discrimination, harassment & victimisation - identifying areas which may treat one group less favourably than another group when providing a service

• Advancing equality of opportunity   - 'Life's chances' – advancing opportunity is essential creating conditions which most people take for granted and yet others because of their protected characteristics may be treated less favourable or excluded

• Fostering good relations between different groups and people- working with different people and communities to increase inclusivity and mutual understanding

An equality analysis (incorporated into this document) is the ongoing process by which LCCG can assess potential risk of discrimination & breach of the Equality Act 2010. This assessment assists LCCG, to identify at stages in the process; any equality implications that may need further review, consultation, or development and help make an open and transparent process. The EIA concerns people and groups who have the following protected characteristics, under the Equalities Act 2010:

• Race	• Sex (gender)	• Religion and belief
• Age (young and Old)	• Disability	

- Marriage or civil partnership (employment only)
- Pregnancy and maternity
- Sexual orientation
- Gender reassignment

This document incorporates EIA / EA and engagement planning and is the method LCCG uses to demonstrate meeting both duties. The equalities duty is a process and acts like book ends prior to a decision being taken.

If the PSED applies to a project, certain activities must take place and be reported on before any final decision to implement a programme is made. In most cases, where projects involve delivering services to people, the PSED will apply. Where a manager or project officer thinks the PSED does not apply an explanation of *why this is the case* still has to go to the decision makers as they still have to pay 'due regard' to PSED. The audit trail for this is important if the CCG if challenged.

How does this document help me?

Patient and public participation in the design and delivery of policies and services is vital to making changes that will be effective and will support empowering patients and communities to be actively involved in improving health. This process will plan how to achieve public and patient participation, ensure E&D issues are built into planning early and so meet our duties in both these respects and develop meaningful engagement that is able to improve outcomes. The earlier public and patients can be involved the better. Levels of involvement will vary according to what is being looked at and this guide should help determine what you need to do that is appropriate. If you can involve a few members of the public in scoping out the situation early on, they could support you to sense check proposals and provide appropriate input throughout the process. We have a volunteer programme that can support this so ask the Engagement Team.

This assessment is intended to be completed by the relevant CCG staff lead, with input from clinical and engagement leads. The assessment is best completed as early in the process as possible. It then needs be taken to the Patient Engagement Group for discussion and input, where possible again as early in the concept phase as possible.

What happens after the form is completed?

The engagement group will review proposals, suggest areas that require improvement and identify high risk issues which need to be brought to the attention of Quality Safety and Outcomes Committee (QSOC) and/or Governing Body. An overview and risk assessment report will be completed by the engagement group at the end of the discussion and reported to QSOC. Documentation of this process provides the necessary governance for Equalities and Engagement Duties.

Following the engagement and final Equalities assessment the completed form either in its entirety or the majority of it will be published on NHS Liverpool CCG's website in accordance with requirements to publish equality impact assessments.

NHS
Liverpool
Clinical Commissioning Group

Flowchart for Engagement and Equality Planning & Assessment Process

1

Form 0 agreed.
Discuss with Engagement Team. Identify requirements in form 1.

2

Form 1 Agreed.
Programme lead completes Section 1-4 of Engagement and Equality Planning and Assessment Form for each process / service / policy etc. with Engagement Team input.
Major Service Change identified as appropriate.

3

Form submitted to the Public & Patient Engagement and Experience Group – proposals and risks assessed against both duties and recorded for audit trail. Proposals refined as required/ approved by Lay Member for Engagement.

7

Programme Lead amends service design /policy as agreed

6

Engagement Report & EA published & considered along with any revisions to proposals by programme board/ Engagement Group/QSOC /GB as required.

5

Engagement / consultation carried out, analysed and reported.
Final EA completed.

4

Plans submitted to QSOC/ Governing Body as required.
Major Service Change separate process including NHSE assurance

8

Programme leads/engagement team feedback to identified parties (as agreed within plans).

9

Final outcomes of how engagement & EA influenced service design recorded in Section 6 of Engagement Planning form, including full EIA & reported to Prog Board / Engagement and Patient Experience Group /QSOC / GB

10

Engagement and Patient Experience Group produce report on engagement activity and outcomes as required for Annual Report and to evidence engagement and equality duties being addressed.

Completed forms published on LCCG website after process