Making Progress on Race Equality in Mental Health

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Executive Summary

If we are to ensure that more people have good mental health, and more people recover, we must do more to tackle inequalities in access, experience and outcome in mental health care.

The links between discrimination, disadvantage and poor mental health are well documented. In terms of access to services, experience of care, and other measures of outcomes, historically some social groups have fared less well. Rates of admission to inpatient mental health units, and rates of detention, continue to be higher for 'Black African', 'Black Caribbean' and 'Black Other' groups than for other population groups[1]. Over the past decade, there have been numerous initiatives and programmes aimed at addressing this issue, however, that effort has not resulted in significant change in terms of measurable improvements in outcomes.

This piece of research, commissioned by the Department of Health, set out to seek views from leaders (working as NHS commissioners, providers of NHS services and from local authorities) on what the barriers, as they see them, are to making progress in terms of improving access, experience and outcomes for black and minority ethnic (BME) service users. We were particularly interested to explore, given the end of the Delivering Race Equality Programme, leaders views around what support (if any) in this area they may find helpful.

The authors of this report interviewed twenty nine senior leaders from across the mental health sector. Those respondents largely represent statutory and third sector providers of NHS mental health services. It was particularly difficult to engage NHS commissioners in the research, perhaps not surprisingly given the ongoing changes to the commissioning structure set out in the Health and Social Care Act.

This report sets out a series of observations, based on those interviews, and also highlights examples of initiatives to promote race equality in mental health services. The report also makes a series of recommendations aimed at the Department of Health, NHS Commissioning Board, Public Health England, Healthwatch, Care Quality Commission, Clinical Commissioning Groups (CCGs), providers of NHS mental health services and local authorities.

Observations

The researchers observed that there was significant variability in the way equalities issues, as they relate to service users, are approached in different organisations. All organisations had in place a single or integrated equality plan, but the degree to which race equality was visible within these plans varied. The presence of race equality, or single equality plans, however is not itself an indicator of progress in positive outcomes for BME service users.

The report also highlights the importance of committed leadership. Amongst those interviewed, personal awareness, commitment and drive of, particularly, chief executives, appeared to be associated with a higher degree of board level attention and scrutiny of race

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[1] Care Quality Commission and National Mental Health Development Unit (2011), *Count Me In Census 2010. Available at: <http://www.cqc.org.uk/sites/default/files/media/documents/count_me_in_2010_final_tagged.pdf>*

equality within the organisation. The majority of organisations said they employed at least one equality and diversity lead.

The researchers also observed in their interviews that workforce development, as opposed to service delivery, has been where most resources appear to have been focused and where the most measurable progress has been made. The progress in workforce development may be linked to the responsibility for equalities issues often being located in the Human Resource directorate. This may indicate a need for greater support to support improvements in service delivery and service user outcomes.

Whilst many of the organisations interviewed could cite examples of initiatives in their own organisations aimed at addressing race equality, providing evidence of how this has had concrete effects, including hard evidence around improving outcomes for BME service users, was scarce. This led to the researchers concluding there needs to be greater clarity about the outcomes being pursued, and for organisations to be transparent about progress, so that they can be appropriately be held to account.

In respect of national support and policy, the majority of organisations interviewed were positive about the Delivering Race Equality programme, though they reported that they had made limited local progress in continuing the work since the national programme ended in 2010 in terms of projects for reducing inequalities for BME service users. Whilst interviewees were supportive of *No Health Without Mental Health*, it was commonly viewed to be likely of having little impact without a supporting implementation plan. Interviewees also made comments around the Equality Delivery System and its issues with applicability to mental health settings.

In addition, interviewees commonly cited the impact of the tight financial climate combined with significant change in the health and social care system as both being issues that, by requiring a great deal of attention, would impact on the attention paid to issues around race equality. Other interviewees observed that, with the end of the Delivering Race Equality Programme, there was now a lack of organised national support for sharing positive practice. Others reported a lack of confidence regarding potential solutions in race equality, or knowledge around which initiatives were likely to have the greatest impact.

When asked about what would enable organisations to make progress leaders highlighted four main areas:

1. Developing capacity and capability in commissioning mental health services for BME groups.
2. Improving accountability in the system through better measurement of outcomes for BME service users (commonly referred to as 'performance management').
3. Development of national guidance and best practice guides to spread evidence and knowledge about what works to improve outcomes for BME service users.
4. Establishment of organised networks to allow professionals to learn from each other.

Recommendations

The report makes a series of recommendations, aimed at the Department of Health, NHS Commissioning Board, Care Quality Commission, Public Health England, Healthwatch, CCGs, Providers of NHS mental health services and local authorities. These are summarised below.

Department of Health

1. The first Secretary of State's mandate to the NHS Commissioning Board should include a clear statement of expectation that the Commissioning Board will make progress on health inequalities in general, and specifically on clear measures of access, experience and outcomes for BME mental health service users.

2. The NHS Outcomes Framework, Public Health Outcomes Framework and Adult Social Care Outcomes Framework should all contain complementary indicators of access, experience and outcomes from services, which can be aggregated by ethnic groups. This way, the government will have a clear method in place for holding services to account by outcomes for BME service users.

3. The expected Implementation Framework in support of *No Health Without Mental Health* should include actions relating to improving access, experience and outcomes for BME service users.

NHS Commissioning Board

4. The NHS Commissioning Board should ensure that the Commissioning Outcomes Framework incorporates effective measures for equality, including measures of access, experience and outcomes for BME service users. Where 'outcome' measures are underdeveloped, the NHS Commissioning Board may want to consider what process measures could appropriately act as a 'placeholder'.

5. The NHS Commissioning Board should, as part of plans to develop the capacity and capability of CCGs generally, to provide access to expert support and guidance in relation to commissioning to reduce racial inequalities in mental health. The NHS Commissioning Board may want to consider producing, or commissioning, the development of a toolkit, or similar product, aimed at new commissioners.

6. The NHS Commissioning Board should consider, beyond the Commissioning Outcomes Framework, what other levers are available to them to use in their relationship with CCGs to incentivise action to improve outcomes for BME service users.

7. The NHS Commissioning Board, as a commissioner of primary care and certain specialised services, should consider how they are commissioning for race equality, and how they are monitoring the effectiveness of services by measures of access, experience and outcomes for BME service users.

8. The NHS Commissioning Board will want to consider the feedback in this report on the Equality Delivery System, and consider how to make improvements to ensure an appropriate mental health focus.

Public Health England

9. Public Health England should provide guidance to local public health services on equalities issues, specifically on how public mental health initiatives and programmes can ensure they appropriately target BME service users.

10. Public Health England should consider how the Public Health Outcomes Framework, and any other levers at their disposal, use indicators of access, experience and outcomes from services for BME groups. Progress should be monitored at the level of Public Health England's board.

Care Quality Commission

11. With end of the Count me in census, the Care Quality Commission should consider how it can continue to give a national profile to issues relating to variations in outcomes for people from BME groups, including outcomes from mental health care.

Healthwatch England

12. To be established in October 2012, Healthwatch will play a role at both national and local level, and will make sure that the views of the public and people who use services are heard. At a national level Healthwatch should consider how they will demonstrate from the outset a clear commitment to race equality, and have appropriate representation with regards to protected characteristics.

13. Local Healthwatch should ensure BME representation from service users and carers is reflected in its membership and priority setting.

Clinical Commissioning Groups

14. CCGs should consider how they can appropriately use the levers at their disposal, including use of CQUIN and other contracting mechanisms, to incentivise improvements in services related to clear measures of access, experience and outcomes for BME mental health service users.

15. CCGs, in working with local Health and Wellbeing Boards, should ensure the local Joint Strategic Needs Assessment appropriately identifies mental health need relating to BME communities, and that this informs local commissioning plans.

16. CCG boards should consider what expertise they have to support appropriate commissioning for BME mental health service users, and where they can access appropriate support where needed. Boards will also want to consider whether an annual report or similar, to the board, on progress tackling health inequalities locally, including as it related to BME people using mental health services, would be a useful way of assessing progress internally and informing future planning.

17. As part of the drive for greater openness and transparency around public services data, CCGs should consider how best to make information and data relating on inequalities available to the public, and how they will demonstrate how they are taking appropriate steps to improve outcomes for BME service users.

18. CCGs, like all public services, should consider how best they can demonstrate the action they are taking to engage with diverse communities. CCGs may want to consider the employing the services of Community Development Workers as a way of supporting engagement.

NHS Providers

19. Provider organisations should consider how they currently approach race equality in their organisation, both in terms of workforce and people who use their services.

20. Providers should consider how they currently measure and monitor information relating to access, experience and outcomes for BME mental health service users, and how this forms part of regular board level reporting and discussion. Boards may want to consider receiving a composite race equality (tacking other protected

characteristics into account) report at least once a year on the organisation's progress against identified objectives and priorities.

21. Provider organisations should consider how information relating to access, experience and outcomes for BME mental health service users is used in the development of organisational strategy and work planning.

22. Provider organisations, where they have not done so, should identify an effective framework for addressing race inequality in mental health, making use where appropriate of development toolkits such as the Equalities Organisational Development Toolkit developed by the National Mental Health Development Unit.

23. Providers should consider how race equality forms part of their current staff training and board level programmes of development, plus how race equality should feature in future training and development plans.

Local Authorities and Health and Wellbeing Boards

24. Health and Wellbeing Boards should assure themselves that local Joint Strategic Needs Assessments adequately assess the needs of BME groups as part of its assessment of mental health need. Health and Wellbeing Boards should ensure the findings from those assessments are properly incorporated into the local health and wellbeing strategy and commissioning plans (including jointly commissioned services where appropriate) demonstrating how these relates to improving access, experience and outcomes for BME service users.

25. Local authorities, as commissioners, should examine how their contractual arrangements with mental health service providers address improving access, experience and outcomes for BME service users.

Conclusion

Whilst numerous national and local initiatives have aimed to improve access, experience and outcomes for BME service users, concrete evidence of improvements remain lacking. Race equality in mental health services is a long standing issue, and the personal commitment of many of the interviewees spoken to as part of this research was evident. However, the critical issue remains that we must, as a sector, focus our efforts on improving outcomes for BME service users. Interviewees highlight commissioning, measurement of outcomes, supporting spread of good practice and guidance, and developing networks to share knowledge as all areas that need further attention. The recommendations contained in this report all address those four priority areas, and, if acted upon, have the potential to support progress on this important issue.

Introduction

The links between discrimination, disadvantage and poor mental health are well documented. In terms of access to services, experience of care, and other measures of outcomes, historically some social groups have fared less well. If we are to ensure that more people have good mental health, and more people recover from mental health problems, as the mental health strategy aims to do, we must do more to tackle inequalities in access, experience and outcomes relating to mental health care.

Rates of admission to inpatient mental health units, and rates of detention, continue to be higher for 'Black African', 'Black Caribbean' and 'Black Other' groups than for other population groups[2]. Inequalities and areas of concern in relation to variations based on ethnicity are found in the findings of the final national census of psychiatric inpatients, *Count Me In*[3], published in February 2011 and the national report *Monitoring the use of the use of the Mental Health Act 1983*[4]. Aside from variations across ethnicities, there are also differences arising from gender and other protected characteristics.

Over the past decade, there have been numerous initiatives and programmes aimed at addressing this issue, however, that effort has not resulted in significant change in terms of measurable outcomes, where those measures are, in fact, available. Outcome measures, particularly relating to recovery, are under-developed in mental health care[5]. Following a period of significant investment, particularly through the *Delivering Race Equality in Mental Healthcare* initiative, the *Count Me In* 2010 census of inpatients[6] found that there was little improvement in key measures of race equality, and that in some cases there was a widening of the variations by ethnicity. The Delivering Race Equality in mental health care five year review[7] does however demonstrate that there has been significant effort exerted by national teams, local services, together with service users and carers, in attempting to make improvements.

During February 2011 the Government published *No Health Without Mental Health*[8], the cross-government, all-age strategy for mental health in England. The strategy addresses issues around equalities and of race equality specifically. The strategy states work should include addressing the inequalities that lead to poor mental health, inequalities that result from poor mental health, and inequalities in service provision – in respect of access, experience and outcomes. Given the evidence that social disadvantage is a key driver of ethnic inequalities in mental health[9], this is particularly welcome.

[2] Care Quality Commission and National Mental Health Development Unit (2011), *Count Me In Census 2010. Available at:*
<http://www.cqc.org.uk/sites/default/files/media/documents/count_me_in_2010_final_tagged.pdf>
[3] Care Quality Commission (2011), *Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*
[4] Care Quality Commission (2010) , *Monitoring the use of the use of the Mental Health Act 1983*
[5] Anne Richardson and Rebecca Cotton (2011), *No Health Without Mental Health: Developing an Outcomes Based Approach*, Mental Health Network. *Available at:*
<http://www.nhsconfed.org/Publications/briefings/Pages/outcomes-based-approach.aspx>
[6] Care Quality Commission (2010), Op cit.
[7] Department of Health (2010), *Delivering Race Equality in Mental Health Care: Five Year Review*
[8] HM Government (February 2011), *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*
[9] Cooper, C., Morgan, C., Byrne, M., Dazzan, P. et al (2008), "Perceptions of disadvantage, ethnicity and psychosis", *British Journal of Psychiatry* vol.192, pp.185-190.

Purpose of the report

This piece of research set out to seek views from leaders (working as NHS commissioners, providers of NHS services and from local authorities) on what the barriers, as they see them, are to making progress in terms of equality of access, experience and outcomes for black and minority ethnic (BME) service users. We were particularly interested to explore, given the end of the Delivering Race Equality Programme, leaders views around what support (if any) in this area they may find helpful. Twenty nine senior leaders from across the sector were interviewed. Those respondents largely represent statutory and third sector providers of NHS mental health services. It was particularly difficult to engage NHS commissioners in the research, perhaps not surprisingly given the ongoing changes to the commissioning structure outlined in the Health and Social Care Act.

The report sets out a series of observations, based on the interviews conducted, and also highlights examples of initiatives to promote race equality. The report also makes a series of recommendations aimed at the Department of Health, NHS Commissioning Board, Public Health England, Healthwatch, Care Quality Commission, Clinical Commissioning Groups (CCGs), providers of NHS mental health services and local authorities.

Methodology

Appendix one sets out in detail the methodology employed in this piece of research. The researchers conducted a series of twenty nine semi structured telephone interviews, the vast majority of which were conducted with senior leaders from statutory and voluntary sector providers of NHS mental health services. Respondents were assured their responses would remain anonymous, though in some cases interviewees allowed us to cite examples of their work in this area with permission. Four interviewees were based in local authorities, and one NHS commissioner was interviewed.

Whilst the approach we chose we believe was the best available, given the resources available, it does have a number of weaknesses. For example, a systematic literature review would have provided a more comprehensive list of relevant work and resources related to equalities in mental health, which in turn would have informed the recommendations made. More time would have enabled us to extend and refine our recommendations. In particular, it would have been helpful to speak to a wider variety of providers – particularly from the independent sector. The largest weakness is the lack of commissioner perspective in the interviews. Considerable efforts were made to engage with this group, however given the ongoing changes as a result of the NHS and Social Care Act it was perhaps not particularly surprising this was difficult to achieve.

Themes from Interviews

This section of the report outlines some of the common themes and messages from the series of interviews conducted as part of this research. They are grouped under the following headings:

- Equality governance and leadership.
- Priorities and progress in race equality.
- Impacts of the national policy and frameworks.
- Impact of the financial climate.
- Main obstacles.
- Positive outcomes.
- Potential enablers.

The table included at the end of this report, appendix two, sets out how each interview was structured. Approximately one third of those interviewed were confident enough about how race equality is addressed in their organisation, and in the mental health sector more broadly, to give a response to every question put to them in the interview.

Equality governance and leadership

The need for local planning, leadership and target setting was documented in *Delivering Race Equality (DRE) in Mental Health Care*[10]. Mental health leaders were asked about the nature of the plans they had in place, existing monitoring mechanisms and the person charged with ensuring delivery.

Every participant in this research reported that plans were in place to deliver race equality in mental health in their organisation. This was by way of a single equality plan, a specific race equality plan, or objectives contained within a corporate overarching plan. The vast majority of those interviewed said that their plans incorporated all the aspects of equality (the nine protected characteristics under the Equality Act 2010). In three organisations interviewees stated that objectives relating to equality were incorporated into overarching corporate plans, rather than by a stand alone race equality, or single equality plan.

Almost all of the mental health providers interviewed reported that they monitored progress against at least one relevant objective at board, or trustee, level. All of the organisations interviewed except for local authorities, stated that the board (or equivalent) received periodic reports on equality, which included race equality in mental health. Of those who stated that the board monitored at least one indicator, two said that they did not monitor race equality as a discrete aspect. Two interviewees stated that their organisational objectives were chosen on the basis that they were generic across all protected characteristics, rather than being specific to race equality.

> *"Our E&D Lead is highly skilled at communicating*
> *what is required of the organisation"*

Local authority interviewees reported that race equality in mental health was governed though contract monitoring with mental health providers.

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[10] Department of Health (2005), *Delivering Race Equality in Mental Health Care,* Department of Health.

A third of participants who stated that their board received reports on equality further explained that these were contained within other governance progress reports. Three leaders interviewed described the board's monitoring of equality as being through the review of minutes of sub committees or other sub-board groups. All interviewees who stated that their organisation had board level reporting of race equality in mental health described most of their monitoring mechanisms as occurring sub board level. Five providers said that they applied a traffic light monitoring system to monitor their action plans.

"Our Chairman is fastidious in asking for the
evidence for our claims of success"

Another third of interviewees were unable to describe how information supported governance. A further third of interviewees who did describe their processes reported that either they believed that the mechanisms for monitoring progress in their organisations were not robust enough, or that they were reporting purely activity and outputs. The majority of leaders who participated in this research said that identifying impacts on service user outcomes was problematic.

Five interviewees said their organisations had created a department dedicated to addressing equality issues. Other examples included having an equality officer leading the work, in two organisations champions identified throughout the rest of the organisation.

All interviewees, bar one, reported that equality roles within their organisations are held by staff not in a clinical role.

Priorities and progress in race equality

The majority of interviewees named priorities for race equality in mental health to which their organisations were working. Four interviewees were unable to name their organisational priorities for race equality in mental health.

Seven interviewees responded to a question about progress by referring to the documented objectives of their organisations in relation to race equality and the progress that they had made.

Where organisations were able to describe progress against plans they gave examples during the interviews. Workforce objectives were the most common area where progress was reported and for which interviewees said could be supported with relevant data.

Examples of equalities initiatives

Interviewees provided examples of projects or initiatives aimed at improving outcomes for people from BME backgrounds in mental health. These were most commonly initiatives focussed on (in rank order):

- Workforce development.
- Developing targeted services to engage specific communities.
- Creation of a role or teams to outreach or provide expertise in the organisation.
- Service improvement initiatives.
- Community engagement initiatives.

A number of interviewees cited examples of mentoring schemes. Nottinghamshire Healthcare NHS Trust provided an example of a BME executive mentoring scheme. The scheme aims to help the organisation secure more employees from BME backgrounds in

leadership positions. This scheme has been so successful, it has now been extended to cover all diversity groups. Members of the Trust board and senior managers fulfil the role of mentors[11]. Rethink Mental Illness offer a staff mentoring scheme across their organisation, Reflect, for people from minority groups and this is taken up by people from BME backgrounds. The organisation reported that they have a good diverse staff profile up to the level just below the senior management team and continue to work towards a good representation at all levels, monitoring effectiveness of the mentoring scheme on an ongoing basis

Service based progress was reported by Central and North West London (CNWL) Foundation Trust. They ran a 3-year Focused Implementation Site (FIS) Project, which was an area of investment under the DRE programme. As well as a range of community engagement initiatives the CNWL FIS Project also included a programme of activities to help reduce detentions by people of black African and African Caribbean backgrounds. The evaluation report of the FIS Project identified a small reduction in detention rates in some areas but acknowledged that there was still a pattern of detention for these groups at levels higher than average. Having paid particular attention to access routes via community mental health teams with an analysis of the impact of Early Intervention, Crisis Resolution and Assertive Outreach Teams, CNWL concluded that the challenges are complex involving a range of stakeholders including Criminal Justice Services and require wider system developments changes . One important area that was identified was that of focusing on discharge processes to ensure that culturally sensitive and appropriate support is available to help reduce re-admission rates.

Other interviewees gave examples of how incentives can be used to focus attention on race equality issues. As part of their CQUIN scheme with their commissioners, Oxleas NHS Foundation Trust are looking at understanding pathways into acute mental health services for BME service users, using case note reviews and focus groups.

Sheffield Health and Social Care NHS Foundation Trust provided information about the implementation of the *Respect* initiative, which is a philosophy of care to replace more traditional models of preventing and managing control and restraint. They stated that not only is the *Respect* initiative received more positively in the inpatient setting by staff and patients but local BME community groups acknowledge and appreciate the way in which the Trust has responded to their concerns.

An interviewee from Mind talked about outreach work the organisation does in Tower Hamlets to effectively target Bangladeshi women.

An example from Camden and Islington NHS Foundation Trust was Vibe, a service that supports young people with a first episode of psychosis to gain vocational or educational opportunities. This initiative was said to have a particular success in engaging with people from BME backgrounds.

Community development workers were cited as positive initiatives by leaders from all categories of organisations interviewed in this research.

Impacts of national policy and frameworks

The Coalition government states that the localism agenda is reflective of the demands made by leaders from across all parts of the public sector for them to have greater freedom to

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[11] More information available on the Nottinghamshire Healthcare NHS Trust website: http://www.nottinghamshirehealthcare.nhs.uk/aboutus/equality-and-diversity/?locale=en

respond to the needs of their local communities[12]. Interviewees were asked about their views on national policy, including the mental health strategy, and also for their opinions of existing frameworks, such as the Equality Delivery System. Interviewees were also asked for their reflections on the DRE programme which came to an end in 2010.

Delivering Race Equality (DRE) Programme

The DRE programme was a ten year national programme which ended in 2010. The review of the programme suggested that there are four key areas that any future programme of work should focus on for improving services. Those four areas included:

1. Better monitoring, collection and use of data on ethnicity, race and culture.
2. Taking a single equalities approach.
3. Re-thinking workforce development to improve skills and capabilities.
4. More effective participation by users and carers.

All participants in this research were aware of the DRE programme and agreed that the four areas identified were the right ones to inform future action. With regard to engagement, several participants in the research commented on the need to engage individuals, not just representative or community groups, as not every individual can be represented by spokespeople from their communities.

Almost all of those interviewed supported a single equality approach. Some differentiated this with an integrated equality approach. Many of the twenty nine leaders who were interviewed suggested that there is a risk with single equality that issues specific to a protected characteristic group such as race will be diluted or lost (i.e. only those issues that are common across all protected characteristic groups will be addressed).

Many of the participants in this research took the question about DRE as an opportunity to mention positive experiences of the programme, citing examples of related work that they were aware of, or took part in, as part of the programme.

National Mental Health Strategy

In February 2011, the Government published *No Health Without Mental Health*[13], its cross-government, all-age strategy for mental health in England. The strategy addresses issues around equalities, and race equality specifically. The strategy states work should include addressing the inequalities that lead to poor mental health, inequalities that result from poor mental health, and inequalities in service provision – in respect of access, experience and outcomes. A framework to support implementation is currently being developed, which will focus on local actions to support implementation. Participants in this piece of research were asked their views on the extent to which the strategy supported the delivery of race equality.

Almost all the leaders who participated in this research knew about the strategy, with around two thirds having some familiarity with the content. Participants from providers and local authorities said that they were familiar with the content. For those familiar with the strategy, every leader said that the strategy lacked deliverables, or an implementation plan, and that this was a weakness.

The national strategy is "aspirational"

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[12] Cabinet Office (2010), *The Coalition: our programme for government.* London: Cabinet Office.

[13] HM Government (February 2011), *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*

"It's like motherhood and apple pie with no teeth"

The strategy was described by all participants who were familiar with it as containing nothing to disagree with, but lacking traction and specific deliverables. In relation to the question of the strategy's potential to support the race equality agenda, half of those familiar with the strategy welcomed the equality section, but all questioned the impact that this aspect of the strategy will have on race equality specifically. Most of these participants said that the content in relation to race was not specific enough in terms of intended outcomes and outcome measures.

Equality Delivery System

The Equality Delivery System (EDS) for the NHS is a framework for assessing current levels of performance in relation to race equality and for establishing a programme of improvement. It is generic across the NHS and is applicable to both commissioners and providers. It was issued in July 2011 and formally launched in November 2011.

*"The information we gathered helped us
focus our work"*

*"Because we have already been working on a clear
plan I worry that it will prove to be a distraction"*

Almost all of the statutory providers that participated in this research were familiar with EDS. Not all had made a final decision about whether or not to introduce it into their organisation. Two statutory providers cited the EDS as the key driver for their work programme on race equality. Most local authorities, voluntary sector organisations and other participating organisations knew of the EDS, with some engaged in its local use.

Most organisations that took part in this research, and who were familiar with the EDS, said that it was, or had the potential to be, positive. Two organisations explained that their organisation are discarding earlier plans, in which they had invested a great deal of time, in order to complete the EDS.

A few organisations were less positive about EDS as they believed that the approach is too bureaucratic. One commented "*personally, this represents everything that is wrong*" when referring to the amount of data that is required to be collected. Several leaders were concerned about the amount of data collection that was needed. This was qualified on at least one occasion with a questioning of the relevance of collecting data on some protected characteristic groups (e.g. sexual orientation and marital status).

Some of the leaders who participated in this research volunteered that they doubted that boards will be happy seeing red areas in the red-amber-green rating system used by the EDS. The lack of mental health focus within EDS was cited by participating organisations as a factor that might reduce its effectiveness and relevance to mental health.

Impact of the financial climate

Interviewees were asked for views on how they saw the current funding constraints (and in the case of many local authorities, reductions in funding) potentially impacting on work relating to race equality.

*"We loose the ability to employ staff whose specific
focus is to deliver on the equalities agenda"*

Every interviewee said that the contraction in public sector finances had an impact, or had the likelihood to impact, race equality in mental health. Responses generally focussed on the following three concerns:

1. Loss or reduction of specialist staff.
2. Loss of preventative services that could have a disproportionate negative impact on BME groups.
3. Loss of focus on race equality in mental health, given the focus on major service changes and financial issues.

A minority of the twenty nine leaders interviewed suggested that the current financial situation had little or no impact on their organisation.

Participants said that the financial climate was leading to a clearer focus on efficiency and outcomes, and therefore had the potential to improve outcomes for people from BME backgrounds. One local authority participant said that the need to undertake equality impact assessments on service changes had pushed equalities further up the agenda. The most frequently reported example of negative impacts of the financial situation relating to race equality were cuts to the number of Community Development Worker posts.

Opportunities and Barriers

Interviewees were asked to identify whether delivering the race equality agenda locally had led to the emergence of opportunities. Interviewees were also asked to identify whether there had been any barriers and what these were.

Opportunities

Almost all the leaders interviewed offered that the DRE programme had been enabling. Better community engagement was most commonly given as a concrete benefit of DRE. The *Count Me In* census carried out by the Care Quality Commission, and its predecessor the Healthcare Commission, were also cited frequently as enabling. Many valued the information that this initiative offered and the ability of their organisation to benchmark against others.

Whilst better community engagement was valued by a large number of organisations, an equal number highlighted this as an area that continues to need further development.

Obstacles

The absence of a national support structure (for example, to dynamically share positive practice) was volunteered by well over half of the participants, largely (though not exclusively) from statutory providers. In relation to this, several highlighted that they believed a void had been left by the closure of the National Mental Health Development Unit.

A lack of steer from commissioners around equalities issues were reported in many interviews with statutory providers. Some expressed this as a perception of a lack of interest. Several described the equality agenda as being totally absent from the commissioning process.

Lack of capacity, and competing priorities, were cited as a significant barrier by many participants. The rapidly changing operating context was frequently cited as a barrier. A barrier to progress cited by a minority of participants involved perceived difficulties in engaging with some communities. Some leaders said that certain BME communities were resistive to engage with mental health organisations due to concerns about stigma.

A number of organisations stated that they lacked the confidence or expertise to analyse what action is required to tackle variation with regard to race equality. Respondents from some areas in the country described serving areas of minimal diversity, or many diverse communities that were small in population. This meant, they believed, that they struggled to develop sufficient expertise and knowledge regarding these communities.

> *"A lot of staff are locked in the traditional way of doing things"*

> *"Lack of senior management 'buy-in' inhibits progress"*

Several leaders interviewed described slow progress in changing staff attitudes, knowledge and skills around race equality in mental health.

Potential enablers

Interviewees were asked to comment on what would most enable them to make progress. Two participants suggested that they should continue to do more of what they are currently doing. One of these organisations had not been able to identify where they had made demonstrable progress on race equality, whilst the other was able to identify areas of progress.

> *"Lack of benchmarking data"*

There were significant commonalities in the responses volunteered by participants regarding what would most enable organisations to take this race equality forward. The four areas identified were:

1. Developing capacity and capability in commissioning mental health services for BME groups.
2. Improving accountability in the system through better measurement of outcomes for BME service users (commonly referred to as 'performance management').
3. Development of national guidance and best practice guides to spread evidence and knowledge about what works to improve outcomes for BME service users.
4. Establishment of organised networks to allow professionals to learn from each other.

Commissioning was the most commonly cited enabler, and particularly the need to expand GPs knowledge of the equalities agenda. Making this a required part of the contractual process, and holding providers to account on outcomes (an expectation of 'performance management') were suggested to be a key aspect to enabling progress. The need to hold CCGs themselves to account over equality issues was also highlighted. Four participants in the research highlighted the need to widen the focus to beyond health.

Whilst 'targets' were generally viewed negatively, several respondents said that they would be the solution as far as race equality and the equality agenda was concerned. Making delivering race equality a 'must do' was described as the most effective way of taking the

agenda forward. Several participants said that setting goals resulted in greater focus and priority within organisations.

National support was identified as a key to progress. As part of the wider equality agenda, race equality must have a high national profile. Interviewees suggested it would be helpful to have a broad strategic perspective of issues, to have access to support and expertise. Participants also commented it would be helpful to be able to benchmark performance on equalities. In terms of specific products, interviewees suggested best practice frameworks and implementation guides (which clearly link between equality issues and the causes of mental ill health) would be helpful. Participants also said resources that set out the evidence for reducing inequality in service provision and improving outcomes would be welcome.

Lastly, three participants states that the NHS needed to take positive action to ensure that more chief executives were from a BME background.

Discussion

Based on the themes from the interviews outlined in the previous discussion, this section sets out a series of observations and discussion as to what they imply for the recommendations made in the following, and last, section.

Equality Governance and Leadership

Researchers found significant variability in terms of progress, commitment, knowledge and understanding demonstrated amongst participants interviewed. Across some organisations there did not appear to be a robust framework in operation, delivering a response based on solid governance and accountability, rather than personal commitment and will.

The inclusion of equalities within the portfolio of a senior manager was not on its own a reliable indicator of the extent to which there was board level commitment, understanding and prioritisation.

As outlined earlier, few respondents were able to demonstrate how plans to address race equality have resulted in improved outcomes for BME service users. Twenty five of the twenty nine organisations that described plans were unable to indentify demonstrable improvements in service user outcomes, though many could describe progress in relation to the workforce. One organisation that did not have a specific race equality plan, or single equality plan, appeared to be delivering specific improvements by incorporating race equality objectives into a corporate business plan. Therefore, the degree of specificity about intended outcomes and also the mechanisms for implementation and monitoring are critical. Outcome measures in mental health are underdeveloped, so developing measures that can allow comparisons between population groups is important. Where race equality is treated with the same priority as other business critical issues it is, perhaps, more likely that improvements will be delivered.

The critical role of monitoring, combined with demonstrable senior leadership, was apparent in this study.

Progress, Priorities and Outcomes

At a national level, the DRE programme five year review[14] highlighted the investment of £2m to drive change and the funding of £16m for community development workers routed through Primary Care Trusts. Whilst it is important to assess whether positive impacts on outcomes for BME service users have been made as a result of past programmes and projects, the worsening of, for example, the variations in admission rates for some BME groups[15] does not necessarily reflect a lack of effort at a service level. Many positive achievements were highlighted in the five year review but some of the intractable inequalities persist, perhaps reflecting over optimism over the degree of change that can be achieved in a short space of time[16].

Progress has been limited in many organisations, despite leaders stating a commitment of the organisation to this agenda. Causes of race inequality are systemic and multi-factorial and responses need to be both proportionate and sophisticated. However, there was little

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[14] Department of Health (2010), *Delivering Race Equality in Mental Health Care: Five Year Review.*
[15] Care Quality Commission (2011). Op Cit.
[16] Ibid

recognition of the lack of demonstrable outcomes for service users in many organisations where no measurable progress had been made. Whilst a few had plans that they hoped would bring about positive outcomes in the future, other interviewees appeared content in the progress of their organisation being focused on workforce.

Local authority participants relied upon the contracting process with mental health providers for delivery of their responsibilities around race equality in mental health. The Directors of Adult Social Services that were interviewed were confident that there was some coverage of race equality in contract monitoring and reviews but were unable to identify the detail. The local authority leaders at assistant director level, who participated in this research, had a significant grasp of the mental health initiatives for race equality but they were also candid in accepting that they had gaps in their knowledge, despite their commitment to the agenda.

There appeared to be a bias towards urban and inner city areas in terms of progress and knowledge about race equality issues. Though most organisations covered both rural and urban areas, the areas more densely populated with people from BME backgrounds (even within organisations) were the focus for initiatives. Having a challenging community voice appeared to help give race equality initiatives prominence on local agendas. The leaders interviewed often spoke about race equality initiatives as emerging from local dialogue with communities.

All senior leaders were clear that race equality should be a priority, though were often candid about their lack of grasp. The issues with which race equality competes, for attention and resource, include some with clear national monitoring and clear consequences of breaches. Progress against priorities was hampered by competing demands on the time, resources and attention of organisations. Ascribing priority to organisational objectives generally is largely a feature of both the external forces (e.g. national policy and regulation) and the culture of the organisation. The findings of this study suggest that leaders in mental health would not describe race equality as a *low priority,* but rather as a *squeezed priority.* In interpreting this distinction it is important to focus not on intention but on impact and outcome.

The seemingly intractable challenges to improving outcomes are discussed in *Inside Outside*[17] the precursor the national policy Delivering Race Equality in Mental Healthcare. If current levels of prioritisation do not achieve intended improvements in outcome, perhaps greater prioritisation is needed in relation to identifying the nature of input and not just to amount.

The single equalities approach appears to introduce a risk that the specific issues related to race equality become lost in the drive to cover all protected characteristics. In pursuance of the single equality approach some organisations have focused exclusively on inclusive priorities that relate to all of the protected characteristic groups. This was seen in the limited number of objectives that specifically addressed the needs of BME service users. It would appear that there is a need to expand knowledge on the inter-related inequalities that people face in relation to identifying with more than one protected characteristic (as defined within the Equality Act 2010).

The changing environment in health and social care was thought by interviewees to be having an impact on progress. A number of interviewees thought that recent mergers of mental health trusts with non mental health community services had impacted on the agenda. Those interviewees thought community providers had made little progress with race equality, and that therefore the focus of merged organisations had shifted to bring these

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[17] Department of Health (2003) *Inside Outside: Improving Mental Heath for Black and Minority Communities in England.*

parts of the organisation up to the level of the mental health functions of the organisation. That, said some interviewees, has diverted attention and resources away from furthering progress in mental health.

National Policies and Frameworks

Leaders appeared to be concerned about the lack of a clear steer nationally. This is either because of a lack of detail about what action is required, or because of the lack of relative profile given to this issue.

The responses of leaders in relation to the Equality Delivery System reflected tension between localism and mandating central action. This was compounded by a lack of expertise locally. Organisations that were working through clear equality plans with good governance appreciated the potential of the EDS to be beneficial, but saw it as a threat to delivery (i.e. yet another process that could absorb energy away from pursuing a set of objectives intended to improve outcomes). Adoption of the EDS is voluntary, and as such organisations are free not to use the model if they choose not to. Conversely, for some organisations a lack of clarity on national requirements can sometimes be perceived as unhelpful. The lack of a national steer, and a lack of specific indicators relating to improving access, experience and outcomes from treatment for BME service users, is problematic.

Despite five year programme of investment (DRE) the baseline of understanding, data and direction is low.

Impact of the Financial Climate

Over half of interviewees stated that the financial constraints were not an excuse for a lack of progress. However, there were differences in the degree to which the constraints (and in some cases contractions) on funding are impacting on race equality initiatives. Whilst cuts to direct service provision may reduce capacity if not carefully considered, cuts to race equality initiatives can potentially result in a widening of inequality, putting into reverse any steps that might have been taken to eliminate, or reduce, that inequity.

Opportunities and Barriers

A frequently cited issue relates to the lack of available organised national support, particularly for sharing positive practice and learning. A powerful message from the research is that despite the efforts of DRE programme, and the many years of attention given to race equality in mental health, there is still a lack of confidence in the system about potential solutions.

Lack of appropriate resources were cited by some participants in this research as an obstacle to making progress. There are, however, examples where fairly well resourced departments have not made effective operational links, and rather than enabling progress, bureaucracy has increased for operational staff.

Several organisations used involvement in the research as an opportunity to reflect on their progress. In addition to this several organisations used the opportunity to directly seek advice on issues. These ranged from which approach to take with regard to integrated equality to strategic planning and legislative issues.

Potential Enablers

Many interviewees cited commissioning as an important enabler for future progress.

Commissioning is a large focus of current NHS reform. Effective commissioning can ensure action plans can be service user outcome focused, as well as hold providers to account for delivering on specific measures relating to race equality. Greater collaboration with partner agencies is crucial in this work.

Recommendations

Whilst numerous national and local initiatives have aimed to improve access, experience and outcomes for BME service users, concrete evidence of improvement remains lacking. Race equality in mental health services is a long standing issue, and the personal commitment of many of the interviewees spoken to as part of this research was evident. However, the critical issue remains that we must, as a sector, both at a national and local level, focus our efforts on improving outcomes for BME service users. When asked about what would enable organisations to make progress leaders highlighted four main areas:

1. Developing capacity and capability in commissioning mental health services for BME groups.
2. Improving accountability in the system through better measurement of outcomes for BME service users (commonly referred to as 'performance management').
3. Development of national guidance and best practice guides to spread evidence and knowledge about what works, and to support improved outcomes for BME service users.
4. Establishment of organised networks to allow professionals to learn from each other.

The recommendations contained in this section all address those priority areas, and, if acted upon, have the potential to support progress on this important issue. Recommendations, aimed at the Department of Health, NHS Commissioning Board, Care Quality Commission, Public Health England, Healthwatch, CCGs, Providers of NHS mental health services and local authorities.

Department of Health

The Department of Health has a key role to plays in raising the profile of race equality, as part of a wider equality agenda, across health and social care.

1. The first Secretary of State's mandate to the NHS Commissioning Board should include a clear statement of expectation that the Commissioning Board will make progress on health inequalities in general, and specifically on clear measures of access, experience and outcomes for BME mental health service users.

2. The NHS Outcomes Framework, Public Health Outcomes Framework and Adult Social Care Outcomes Framework should all contain complementary indicators of access, experience and outcomes from services, which can be aggregated by ethnic groups. This way, the government will have a clear method in place for holding services to account by outcomes for BME service users.

3. The expected Implementation Framework in support of *No Health Without Mental Health* should include actions relating to improving access, experience and outcomes for BME service users.

NHS Commissioning Board

The NHS Commissioning Board will be nationally accountable for the outcomes achieved by the NHS and provide leadership for the new system. The NHS Commissioning Board will be ultimately responsible for holding the NHS to account in relation to the equality agenda. Support of this agenda needs to be explicit with clear expectations that commissioners must demonstrate that they are meeting their obligations in relation to race and mental health.

4. The NHS Commissioning Board should ensure that the Commissioning Outcomes Framework incorporates effective measures for equality, including measures of access, experience and outcomes for BME service users. Where 'outcome' measures are underdeveloped, the NHS Commissioning Board may want to consider what process measures could appropriately act as a 'placeholder'.

5. The NHS Commissioning Board should, as part of plans to develop the capacity and capability of CCGs generally, to provide access to expert support and guidance in relation to commissioning to reduce racial inequalities in mental health. The NHS Commissioning Board may want to consider producing, or commissioning, the development of a toolkit, or similar product, aimed at new commissioners.

6. The NHS Commissioning Board should consider, beyond the Commissioning Outcomes Framework, what other levers are available to them to use in their relationship with CCGs to incentivise action to improve outcomes for BME service users.

7. The NHS Commissioning Board, as a commissioner of primary care and certain specialised services, should consider how they are commissioning for race equality, and how they are monitoring the effectiveness of services by measures of access, experience and outcomes for BME service users.

8. The NHS Commissioning Board will want to consider the feedback in this report on the Equality Delivery System, and consider how to make improvements to ensure an appropriate mental health focus.

Public Health England

The establishment of Public Health England provides an opportunity to drive forward a greater race equality focus within public health, and specifically public mental health.

9. Public Health England should provide guidance to local public health services on equalities issues, specifically on how public mental health initiatives and programmes can ensure they appropriately target BME service users.

10. Public Health England should consider how the Public Health Outcomes Framework, and any other levers at their disposal, use indicators of access, experience and outcomes from services for BME groups. Progress should be monitored at the level of Public Health England's board.

Care Quality Commission

The CQC have a critical role in this agenda with respect to regulating the quality of health and adult social care services in England.

11. With end of the Count me in census, the Care Quality Commission should consider how it can continue to give a national profile to issues relating to variations in outcomes for people from BME groups, including outcomes from mental healthcare.

Healthwatch England

12. To be established in October 2012, Healthwatch will play a role at both national and local level and will make sure that the views of the public and people who use services are heard. At a national level Healthwatch should consider how they will

demonstrate from the outset a clear commitment to race equality, and have appropriate representation with regards to protected characteristics.

13. Local Healthwatch should ensure BME representation from service users and carers is reflected in its membership and priority setting.

Clinical Commissioning Groups

Clinical Commissioning Groups (CCGs) are key to ensuring that local arrangements are fit for purpose and that commissioning provides for the specific needs individuals with protected characteristics. They way in which services are commissioned can define whether diverse needs are given appropriate attention.

14. CCGs should consider how they can appropriately use the levers at their disposal, including use of CQUIN and other contracting mechanisms, to incentivise improvements in services related to clear measures of access, experience and outcomes for BME mental health service users.

15. CCGs, in working with local Health and Wellbeing Boards, should ensure the local Joint Strategic Needs Assessment appropriately identifies mental health need relating to BME communities, and that this informs local commissioning plans.

16. CCG boards should consider what expertise they have to support appropriate commissioning for BME mental health service users, and where they can access appropriate support where needed. Boards will also want to consider whether an annual report or similar, to the board, on progress tackling health inequalities locally, including as it related to BME people using mental health services, would be a useful way of assessing progress internally and informing future planning.

17. As part of the drive for greater openness and transparency around public services data, CCGs should consider how best to make information and data relating on inequalities available to the public, and how they will demonstrate that they are taking appropriate steps to improve outcomes for BME service users.

18. CCGs, like all public services, should consider how best they can demonstrate the action they are taking to engage with diverse communities. CCGs may want to consider the employing the services of Community Development Workers as a way of supporting engagement.

NHS Providers

19. Provider organisations should consider how they currently approach race equality in their organisation, both in terms of workforce and people who use their services.

20. Providers should consider how they currently measure and monitor information relating to access, experience and outcomes for BME mental health service users, and how this forms part of regular board level reporting and discussion. Boards may want to consider receiving a composite race equality (tacking other protected characteristics into account) report at least once a year on the organisation's progress against identified objectives and priorities.

21. Provider organisations should consider how information relating to access, experience and outcomes for BME mental health service users is used in the development of organisational strategy and work planning.

22. Provider organisations, where they have not done so, should identify an effective framework for addressing race inequality in mental health, making use where appropriate of development toolkits such as the Equalities Organisational Development Toolkit developed by the National Mental Health Development Unit.

26. Providers should consider how race equality forms part of their current staff training and board level programmes of development, plus how race equality should feature in future training and development plans.

Local Authorities and Health and Wellbeing Boards

The establishment of Health and Wellbeing Boards provide a good opportunity for addressing the wider determinants of health but they need to prioritise health inequalities in mental health for BME communities. Local authorities have a strategic role in promoting and co producing better health outcomes with their local communities.

23. Health and Wellbeing Boards should assure themselves that local Joint Strategic Needs Assessments adequately assess the needs of BME groups as part of its assessment of mental health need. Health and Wellbeing Boards should ensure the findings from those assessments are properly incorporated into the local health and wellbeing strategy and commissioning plans (including jointly commissioned services where appropriate) demonstrating how these relates to improving access, experience and outcomes for BME service users.

24. Local authorities, as commissioners, should examine how their contractual arrangements with mental health service providers address improving access, experience and outcomes for BME service users.

Conclusion

Whilst numerous national and local initiatives have aimed to improve access, experience and outcomes for BME service users, concrete evidence of improvement remains lacking. Race equality in mental health services is a long standing issue, and the personal commitment of many of the interviewees spoken to as part of this research was evident.

However, the critical issue remains that we must, as a sector, focus our efforts on improving outcomes for BME service users. Interviewees highlight commissioning, measurement of outcomes, and supporting spread of good practice and evidence as all areas that need further attention. The recommendations contained in this report all address those three priority areas, and, if acted upon, have the potential to support progress on this important issue.

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Appendix 1: Methodology

This section explains the methodology used in developing this report, and provides a brief assessment of its strength and limitations.

Research Methodology

The project brief centred on understanding views of leaders, in order to inform future activity around race equality. As with all reports of this nature, we were constrained by the financial and time resources available. The timescale for was relatively short, with work to be carried out over the period of Autumn / Winter 2011/12.

The researchers conducted a series of twenty nine semi structured telephone interviews with sector leaders, predominantly at Chief Executive or Director level. The vast majority of interviews were conducted with leaders from statutory and voluntary sector providers of NHS mental health services. Four interviewees were based in local authorities, and one NHS commissioner was interviewed. Interviewees who participated this study were from each of the 9 NHS[i] regions in England.

Interviewees were identified by a mix of methods. Some had responded to an email to all members of the NHS Confederation's Mental Health Network alerting them to the study and inviting volunteers to participate. Others were identified through follow up email invitations and telephone calls.

Respondents were assured their responses would remain anonymous. Participants were advised that non-attributable comments may be used in the final piece of research. Where the report highlights examples of good practice, we have sought permission to cite those examples.

Who we interviewed

Interviewees represented the following types of organisations:

- 4 Local authorities
- 19 NHS mental health trusts
- 4 Voluntary sector mental health providers
- 1 Commissioner
- 1 National NHS Provider

In terms of the role of each of the interviewees, our sample included:

- 7 Chief Executives of statutory mental health service providers.
- 9 Executive Directors from statutory mental health service providers.
- 1 Non-Executive Director
- 2 Equality and Diversity Lead
- 1 Development Manager
- 1 Head of Service (with lead for equality and diversity) in a statutory mental health provider.
- 1 Human Resources Manager
- 2 Chief Executives of national voluntary sector organisations
- 1 Director of a national voluntary sector organisation

- 1 Chief Executive of a Primary Care Trust
- 3 Directors of Adult Social Care in Local Authorities
- 1 Assistant Directors of Adult Social Care in Local Authorities
- 1 Head of Mental Health in a national statutory NHS organisation

Strengths and limitations of the methodology

We chose this particular methodology as it would enable us to speak to a broad cross section of leaders, and gather qualitative information in a way which allowed views to be fully explored.

Whilst the approach we chose we believe was the strongest available, given our resources, it has a number of weaknesses. For example, a systematic literature review would have provided a more comprehensive list of relevant work and resources related to equalities in mental health, which in turn would have informed the recommendations made. More time would have enabled us to extend and refine our recommendations. In particular, it would have been helpful to speak to a wider variety of providers – particularly from the independent sector. The largest weakness is the lack of commissioner perspective (bar one) in the interviews.

There was a 10% take up rate to the NHS Confederation Mental Health Network's email to mental health service providers requesting volunteers to participate in the study. The researchers sent out further invitations to similar contact groups. Further contacts were made with NHS commissioners, including both via the NHS Confederation's PCT Network and targeted emails from the researchers. The lack of commissioner and for-profit provider interviewees are an acknowledged weakness in the study, though perhaps not a surprising problem to encounter given the changes resulting from the Health and Social Care Act.

Content of interviews

Appendix Two sets out an interview schedule detailing the structure of the interviews and questions used. The interviewees were asked their views on the following topics:

- Equality governance and leadership
- Priorities and progress in race equality
- Impacts of the national policy and frameworks
- Impact of the financial climate
- Main obstacles
- Positive outcomes
- Potential enablers

Interviews were transcribed, and key words and themes that regularly emerged were identified. Omissions were also identified (see discussion).

Appendix 2: Interview Schedule

Introduction	
1	Introductory comments 1. Introduction / Purpose of study 2. Accountability Afiya and NHS Confederation, commissioned by the Department of Health 3. Personal Bio 4. Output 5. Timescale 6. Anonymity 7. Contact for follow up
2	Organisation Type and Demographics Type of organisation *(NHS Provider/ Private Sector Provider/ Third Sector Provider/ Commissioner)* Level of interviewee Region Inner city or rural? Population served?
Equality Mechanisms	
3	Do you have: **3.1** a race equality plan? **3.2** a single equality plan?

4	How is it monitored? **4.1** Director-led committee ? **4.2** Working group? **4.3** Other?
5	**5.1** Who leads on equality work in your organisation? • Race equality lead • Executive director • Non-executive director **5.2** What are the operational reporting mechanisms, with, e.g.: Board reports? • Management team objectives? • Team objectives? • Inpatient service delivery functions? **5.3** What are the operational linkages with, e.g: • Audit functions? • Care management functions? • Commissioner equality and diversity mechanisms? • Community mechanisms – e.g. Links, other? •
6	What priorities relating to race, if any, have been identified by your organisation?
7	**7.1** Describe progress against plans/priorities in relation race? **7.2** What mechanisms do you use (or could you use) to rate the extent of implementation (e.g. completed objectives, partially complete or little progress)

8	**8.1** Are you aware of the Equality Delivery System for performance management of equality objectives in the NHS ? **8.2** If so, would you say it has had: • Significant impact • Some impact • Little impact Please explain
Financial considerations	
9	What is the impact of the current financial climate on your organisation's ability to progress: **9.1** race equality duties? **9.2** general equality duties?
Policy considerations	
10	Is the national mental health strategy – *No health without mental health* - helpful/not helpful in promoting improved services to black and minority ethnic communities? Please explain
11	The DRE programme identified a number of areas for improving services. These included: a) Better monitoring, collection and use of data on ethnicity, race and culture; b) Taking a single equalities approach; c) Re-thinking workforce development to improve skills and capabilities d) More effective participation by users and carers **11.1** Are these about right? If not, why not? **11.2** What would you consider most workable? **11.3** What is the experience in your organisation of progressing better race equality outcomes? **11.4** What obstacles have you encountered? **11.5** What opportunities have emerged? Why?

Improving outcomes	
12	What examples can you point to in your organisation where there have been demonstrable achievements / successful improvements in outcomes for people from BME communities?
13	What would most enable your organisation to make demonstrable improvements in outcomes in relation to race or the equalities agenda
14	Any other comments?

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i The formal configuration of Strategic Health Authority area, co-terminus with local government regions are: East Midlands, East of England, Greater London, North East, North West, South East, South West, Yorkshire and Humber