

Hertfordshire, Bedfordshire and Luton Mental Health Trusts: Focus Implementation Sites Report 2009



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1.0 INTRODUCTION

The CSIP Equalities Lead for the Eastern Region commissioned this report to present an overview and summary of the Focused Implementation Sites (FIS) in the Eastern region. In preparation, a preliminary meeting was hosted to discuss and agree the broad principles, structure and content of the final report.

1.1 Background and Context

In January 2005, the Department of Health published the comprehensive action plan “Delivering Race Equality (DRE) in Mental Health Care”, which incorporated the Government’s response to the report into the death of David Bennett. The Action Plan aimed to ensure the strategic direction of travel moved towards a position where people from BME communities gained greater confidence in mental health services. The key objective was to assist in the elimination of discrimination and to achieve equality in mental health care for all people from a black, minority ethnic background. The Action Plan formed a key aspect of the Department of Health’s wider equality and human rights strategy and was developed to work across an entire system. This was to be implemented by all NHS and social care organisations, and was to facilitate all NHS Trusts to achieve compliance under the Race Relations (Amendment) Act 2000.

The National DRE Action Plan is based on three building blocks of reform:

1. Better and more responsive services – achieved through action to improve mental health care for black and minority ethnic patients, developing a more culturally capable workforce
2. Better engagement of services with the local communities – achieved by engaging communities in planning services
3. Better information – from improved monitoring and better dissemination of information

Successful delivery of the DRE Action Plan will be considered in 2010 where mental health services will be assessed against 12 characteristics which are:

1. Less fear of service among BME communities
2. Increased satisfaction with services
3. A reduction in the rate of admission of people from BME communities to inpatient units
4. A reduction in the rates of compulsory detention of BME service users
5. Fewer violent incidents that are secondary to inadequate treatment
6. A reduction in the use of seclusion in BME groups
7. The prevention of deaths in mental health services following physical intervention
8. More BME service users reaching self reported states of recovery
9. A reduction in the ethnic disparities found in prison populations
10. A more balanced range of effective therapies, such as psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective
11. A more active role for BME communities and BME service users in the planning and provision of services
12. A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

1.2 Focussed Implementation Sites (FISs)

Focussed Implementation sites were multi-agency projects charged with the task of trying out new ways of working and being the main framework for delivering the actions detailed in DRE. The Action Plan identified the requirements for the establishment of seventeen focused implementation sites (FIS) across the country.

The structure of FIS sites varied quite considerably in relation to size and demography. However, it was recommended that all sites demonstrated evidence of partnership working and was to include an agreement with the Strategic Health Authority, along with evidence of commitment at a senior level, such as a director from an organisation. This was to include primary care trusts, local authorities and the voluntary sector. Each FIS could decide to work as part of, or across SHA boundaries.

The purpose of the Focussed Implementation Sites was to:

- Fast track the DRE action plan over a three year period from April 2005 to March 2008
- Facilitate and guide delivery of the DRE programme
- Pilot initiatives at a local level
- Share good practice
- Encourage and support partnership working
- Develop strategic partnerships between key organisations to encourage investment and build capacity
- To have agreed and robust action plans in place – centred around the three building blocks
- Build capacity and intelligence to facilitate further change
- Rapidly improve mental health services for BME populations
- Improve access to mental healthcare
- Provide more appropriate and responsive services
- Develop a more skilled workforce that can be responsive to the needs of a diverse population
- Develop capacity with community and voluntary organisations
- Help to demonstrate that change can be achieved
- To demonstrate that a whole systems approach improves mental health services for BME groups
- Provide leadership and raise the profile of the BME programme

Work to implement the DRE Action Plan has progressed nationally through the Focused Implementation Sites (FIS).

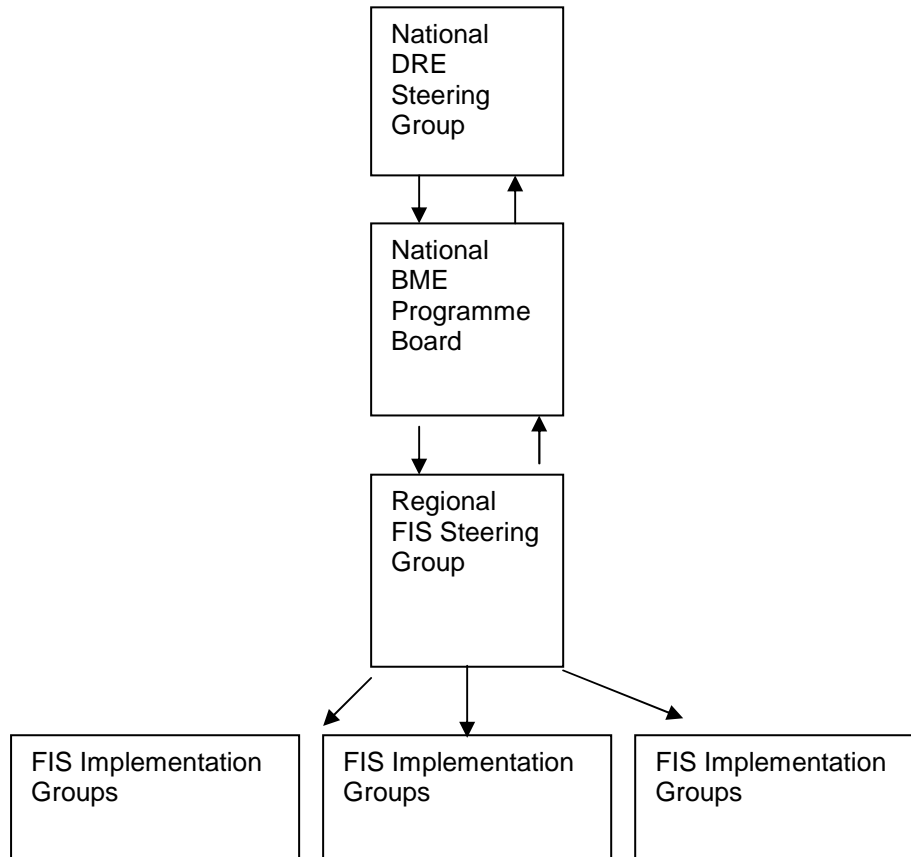
1.3 Leadership and Governance

Initially there were specific milestones to be achieved within a short time scale; therefore a check list for the FIS activities was produced to assist in the development and implementation.

Given the whole systems nature of the initiative it was important to establish a robust governance structure that covered the whole of the FIS area. It was recommended that development of a FIS steering group ensured an appropriate reporting structure into: A national DRE steering group; a national BME programme board; and local FIS Implementation groups.

Mental health focused groups/project boards were established to assist in steering and supporting delivery of the remit.

Presented is an illustration of a recommended reporting structure:



It is important to highlight that although a framework was recommended, governance structures differed according to regional variations.

Development of local steering groups, were to consider the following aspects:

- The underlying principles
- The purpose of the group
- The stakeholders and were they represented
- Consideration of the community and voluntary dimensions
- How the structure linked into existing groups such as Race Equality groups
- Connections with CAMHS and Older People's Standard 7 leads
- How people used mental health services
- Involvement of their carers and support provided for them to enable engagement
- Resource implications, e.g. travel, childcare?

To further assist the development of a local model of governance, the following was presented as the recommended framework for a FIS implementation group:

- The group should be developed to work across all age groups
- To adopt the principle of open partnership working as an essential criteria
- To ensure the remit covers the wider equality strands in relation to age, gender, culture, race, religion and sexual orientation
- The group should focus on access to services as an essential criteria
- The group should ensure quality, by being service user focussed
- The group should be outcomes focused
- Socially excluded groups should be encouraged to be directly involved in the group
- The group should be orientated to mental health recovery as a foundation to all its work.

1.4 DRE Input and Resources

There was an obligation for NHS and social care organisations to implement the national action plan through mainstream allocations. However, it was proposed that nominated sites should not be financially penalised, therefore each FIS was allowed to bid for up to £50,000 to use for an innovative scheme of work.

1.5 Expected Outcomes of a FIS - Nationally

- Additional information on practical steps to deliver appropriate and responsive services
- Development of the knowledge base on the effectiveness of the action plan
- Greater capacity to drive change on a national level
- Harmonised whole systems care with commitment to the action plan model
- Managerial capacity widely available to colleagues involved in rolling out the action plan.

1.6 Development of Hertfordshire Bedfordshire and Luton Mental Health Trusts Focus Implementation Sites

Within the Eastern region there were two Focused Implementation Sites. Following SHA reconfiguration, Hertfordshire and Bedfordshire FIS became known as Bedfordshire and Luton FIS, with Bedfordshire and Luton Partnership NHS Trust working as the main stakeholder. Following a successful bid to the DRE programme this FIS was allocated the entire £50,000. Hertfordshire Partnership NHS Trust did apply to become a FIS but was unfortunately unsuccessful. Later on Hertfordshire Partnership NHS Trust established a FIS. However, due to the fact that this was established after the initial wave of focus implementation sites (FIS), it became known as a '*shadow FIS*,' which initially did not receive funding from the DRE Programme. However, the report will detail that the CSIP Equalities Lead from the Eastern region was successful in securing the Hertfordshire FIS £13,000, along with financial allocations from Hertfordshire Partnership HNS Trust and the Joint Commissioning Team to fund a programme of work detailed in the action plan. The report will now outline the key activities that took place to implement the FIS in the East of England region.

2.0 BEDFORDSHIRE AND LUTON FIS

Bedfordshire and Luton has a population of approximately 565,943 (2001 census data) with 35% from a BME background. It was important that the report draws attention to the demographic variations, as this influenced service delivery in the regions. Luton has a population of 184,371 with 28% from a BME background, whilst Bedfordshire has a population of 381,572 with 6.6% from a BME background. To ensure that stakeholders had the opportunity to have a direct input into the review of the FIS, a meeting was arranged to obtain a representative view, this meeting took place in Luton. Attendees at the meeting were asked to: Review and consider the aspects of the FIS that worked well; to review areas that could have been improved; to highlight what lessons had been learned in pursuit of delivering the remit and to focus on what steps needed to be considered and taken forward to work towards mainstreaming of the remit.

2.1 The following aspects were highlighted as the key factors that worked well:

2.1.1 Executive level Commitment

The DRE recommendations received high level commitment. There was a real keenness at a senior level to do things right. A paper submitted to the board, outlined the strategic direction of travel. This obtained executive agreement that supported the recommendations from the DRE, to embed national policy at a local level.

The FIS provided an excellent foundation to trial and evaluate new initiatives, and encouraged organisations to carry out impact assessments. Bedfordshire and Luton completed impact assessments' on all their policies.

2.1.2 Workforce

The recruitment of Community Development Workers (CDWs) was regarded as a key component to deliver the DRE remit. Each mental health trust was allocated a target to recruit a specific number of CDWs. Bedfordshire and Luton recruited to post the total number of CDWs and successfully achieved their target.

2.1.3 Workstreams

The positive impact of the work delivered by the CDWs was demonstrated where:

- CDWs coordinated the establishment of faith rooms
- CDWs encouraged the development of BME staff networks to provide a forum for staff to promote and share good practice
- CDWs promoted the appointment of equality champions who worked as a point of contact to deliver the remit.
- CDWs encouraged mentoring arrangements across the footprint to a number of staff. This was to provide a confidential support network outside of the mainstream line management structures.

2.1.4 Partnership working - Community Engagement Initiatives

There were a number of community engagement projects that worked very well and provided the opportunity to train up service users.

- The FIS funded a BME Counselling service up to £15,000 where service users were involved in delivery of the service. The financial allocation greatly benefitted service delivery. As it equated to two years funding and enabled the service to increase the number of sessions they were able to deliver. Prior to the financial allocation, the service had been working to a lengthy waiting list which was significantly reduced. Successful delivery of this project assisted to improve community engagement with the PCT.

- The FIS Action plan was well thought through and was developed with direct input with the involvement from community groups.

2.1.5 Impact on strategic planning and procedures

CDWs were tasked to undertake significant pieces of work. A number of work streams were reviewed by the CDWs, to ensure that what was being delivered was fit for purpose.

An evaluation of the recruitment practices and cultural competency training was carried out. Following completion of the cultural competency training the outcome of the reviews was as follows:

- There was a requirement for more detailed training to be delivered to staff,
- There was a necessity to amend the data collection categories that enabled statistical information used by organisations to be available to the general public.
- The information collected is now of a higher quality and has created the facility to provide good intelligence to inform and shape service delivery

Improvements in monitoring, resulted in a more culturally competent service, with better links to GPs, along with more use of evidence based assessment tools.

2.1.6 Resources

The recruitment of CDWs resulted in the continued delivery of significant pieces of work that started in the FIS, which has worked towards mainstreaming and sustaining initiatives. This was demonstrated in the development and production of resources (directory) that had been distributed to a number of sites. CDWs continued delivery of this work stream, and cascaded the resource packs across a number of sites.

2.1.7 Communication Processes

Channels of communication greatly improved, particularly across voluntary sector organisations. There was a better understanding of the communication processes between the voluntary sector and the mental health trusts.

A number of stakeholder events were hosted to provide a forum to showcase initiatives, network with stakeholders and to share and promote good practice.

A radio campaign was conducted to promote the FIS and to raise awareness to the local community. This campaign received very positive reviews.

A website was developed which greatly improved the relay of information to a wider audience.

2.2 The following was outlined as some of the elements that could have been improved:

2.2.1 Workforce

- The procedure to recruit the CDWs was a lengthy process; therefore they were not recruited into post as promptly as anticipated, which delayed the implementation of workstreams.
- Given the scale of the remit and the stated timeframe to meet the objectives, it would have been prudent to have a dedicated programme lead. As the post of a FIS programme coordinator was too large a role to add onto an existing post.

2.2.2 Partnership Working – community engagement

There were particular aspects of partnership working that gave rise to a number of challenges. The PCT and community stakeholder consultation forums were difficult

to maintain commitment and often experienced a sharp decline along with a fluctuation in group attendance.

To work to address and improve communication channels, consideration could have been given to explore different ways to engage a range of agencies, as opposed to the practice familiar with statutory services.

2.2.3 Strategic Planning and Procedures

To have a significant impact on access and outcomes, representatives at the meeting, asserted that the DRE should have been developed in conjunction with Psychiatrists and Consultants. This would have influenced the model of delivery, and supported the establishment and maintenance of better links within the acute sector.

2.2.4 Resources

There were a number of objectives that had not been achieved. The objectives could have been scaled back, structured around available resources and aligned to the SMART model of project delivery, to ensure they were realistic and achievable.

A view was presented from the forum, that had the financial allocation been significantly increased and directly allocated to the various community groups more would have been achieved.

Additionally, challenges were highlighted that related to links with the commissioning process and the planning of resources. Luton did not have any substantive mental health commissioners for some time, which proved difficult to establish links and engage with the commissioning agenda.

2.2.5 Communication Processes

The remit of the FIS was not widely promoted on a large scale, particularly to commissioners and the SHA, which initially made it quite difficult to engage with key stakeholders.

2.3 The following highlighted what lessons had been learned in pursuit of delivering the DRE programme:

2.3.1 Workforce

- BLPT gained a better understanding of the level of commitment required to implement the equality agenda
- Delivery of the remit required dedicated personnel, as opposed to adding the remit to an existing post which made delivery more difficult.

2.3.2 Partnership Working - community engagement

- A greater insight was gained: Into how community groups worked; the various work streams they delivered and their relationship with commissioners.
- Given the difficulties in engaging with community groups, consideration should have been given to various methods of engagement.

2.3.3 Strategic Planning and Procedures

- How to implement large scale change on a number of levels with a complex initiative
- It is Important for a large scale complex programme to have realistic outcomes and aligned to resources.

2.3.4 Resources

- The way in which the funding was allocated on a non recurrent basis made it difficult to work on long term plans.

2.3.5 Communication Processes

- Community representation informed the review that a greater understanding had been gained on how the trust conducted its business along with a more in-depth awareness of the complexities of the NHS channels of communication and how best to navigate through these complex routes.

- A greater awareness of how to engage with community groups was reported from BLPT who consequently amended meeting times for community groups, which was more conducive to community activity.

2.3.6 How can the positive outcomes be mainstreamed?

The group highlighted the following aspects were necessary to mainstream the initiatives from the DRE:

- Development of a communication strategy would encourage clear protocols and promote the effective dissemination of information.
- A clear directive will help to support Equality Leads and CDWs to work as the main conduit to implement the action plan and encourage a whole organisational approach to initiate change with clear outcomes.
- An incentive system could be put in place where staff are rewarded for identifying new ways of working. This will help to promote the FIS, share best practice and celebrate achievements.
- Merge the two training streams i.e. equality and diversity and the cultural competency training.

2.4 The following aspects were highlighted as the key achievements:

1. 8 CDWs recruited into post with 1 senior CDW post
2. 50 staff attended cultural competency training
3. 20 staff trained to deliver cultural competency training
4. The BME leadership programme was made accessible to community leaders and staff. This enabled joint training to take place
5. The BME mentoring scheme was established across the trust
6. The Breaking Through Programme was rolled out to BME staff
7. 878 people attended equality and diversity training
8. FIS members received training in service improvement techniques to improve pathways and services, and assisted CDWs that informed their future work activities
9. Equality champions were identified and trained to work as the main point of contact for organisations
10. FIS funding supported staff into post and enabled the employment of an administrator and an additional counsellor.
11. Community volunteers obtained paid employment
12. 3 Stakeholder events were hosted that had direct involvement with service users
13. A joint event was hosted to disseminate the findings and recommendations from the three community engagement research projects
14. Spiritual literature was developed and disseminated across the region
15. Findings from community engagement researchers was incorporated into the overall Trust plan
16. There was improved electronic information regarding services and how to access them
17. implementation of the Health collaborative project on Marsh farm was a success

3.0 HERTFORDSHIRE FIS

Hertfordshire has a population of 1,033,977 with 11.2% being from a BME background. The BME communities are largely concentrated in the following wards of: Welwyn Hatfield, Watford, St Albans and Hertsmere. To ensure that stakeholders had the opportunity to have a direct input into the review of the FIS. A meeting was arranged to obtain a representative view that took place in Hertfordshire, where attendees at the meeting were asked to: Review and consider the aspects of the FIS that worked well; review the areas that could have been improved; highlight what lessons had been learned in pursuit of delivering the remit and to focus on what steps needed to be considered and taken forward to work towards mainstreaming of the remit.

3.1 The following aspects were highlighted as the key factors that worked well:

3.1.1 Executive level Commitment

Attendees at the meeting stated there was a real enthusiasm and responsibility at a senior level to bring about change in service delivery. They went on to report, that executive level commitment was evident from the outset and facilitated the programme to move forward. The steering group was chaired by Tom Cahill, who was the Director of Nursing and is now the Chief Executive Officer of Hertfordshire Partnership NHS Foundation Trust. This clearly demonstrated senior involvement to implement national policy at a local level.

The membership of the DRE board facilitated the establishment of excellent networks with the BME community, and also built on existing networks. Key lessons were gleaned from the project in Luton where good practice was shared, particularly in relation to the methodology of project management. This assisted to focus activity and significantly contributed to development of the 2006 - 2010 action plan.

3.1.2 Workforce

The recruitment of Community Development Workers (CDWs) was regarded as a key component to deliver the DRE remit. Representatives at the meeting reported that there was a high degree of enthusiasm at an executive level to recruit into post the allocated target of CDWs. Ten CDWs were recruited. Hertfordshire NHS Trust successfully achieved their target.

3.1.3 Workstreams

Delivery of the DRE involved the implementation of a number of workstreams. The following are examples of a number of initiatives that worked well and were extremely effective:

- Participation of BME Service Users in the delivery of services
- The establishment of CDW local area networks
- The development and implementation of an Asian Women's Project
- The development and implementation of a Bosnian Project
- The establishment of clinical trailblazer sites
- Development and dissemination of a DVD

3.1.4 Partnership working – Community Engagement

Effective partnership work was described as key to successful delivery of the project. Staff worked well, as they had been invited from the outset to have a direct input to steer delivery of the project. There was a real interface between expert service users, which demonstrated the effectiveness of Community Development Workers.

There was good participation from commissioning leads, who had direct input into the programme as board members. This representation was important; as it worked to ensure that the services commissioned were appropriate and met local need.

3.1.5 Strategic Planning and Procedures

Delivery of the DRE had a positive impact and supported new service developments, such as the Introduction of the programme that began in 2006 to improve access to psychological therapies (IAPT) for adults of working age that suffer from depression and anxiety.

3.1.6 Resources

CSIP funded the development and delivery of cultural competency training courses. This provided the foundation to enhance further developments and promote awareness on issues related to people from BME backgrounds.

Attendance on the cultural competency course enabled staff to work more effectively with BME groups. This training was made available to both the statutory and voluntary sectors.

The Trust allocated resources to host a number of positive mental health events.

3.1.7 Communication Processes

A number of events were hosted to showcase and share best practice across Hertfordshire. The events took place to raise the profile and awareness of the project and were targeted to reach the community and service users.

The events were very well attended and reached a range of people who previously had limited knowledge of the programme. Engagement at the events was reported as being very positive, and was concluded with clear action points.

3.2 The following was outlined as some of the elements that could have been improved:

3.2.1 Workforce

A consensus from the meeting stated there was generally a lack of clarity around the remit of the CDWs. Particularly in relation to how the role was associated to key service developments and how they influenced service change. The group highlighted that occasionally the CDWs did not capture the full range of communication that was delivered. Attendees at the meeting emphasised the need to encourage CDWs to use structured communication processes to provide progress reports on their remit.

It was deemed advisable that CDWs be reminded of the building blocks, along with a focus on a number of common themes, to encourage a coherent delivery across the region with clear links to national strategy.

3.2.2 Partnership working – Community Engagement

Effective partnership working was considered as a key component to successful delivery of the programme; however the following issues were highlighted as challenges:

- Representation on the board did not rotate from various groups - to gain a wider representative view and engage a wider ethnic group
- There was inconsistent representation from a number of partners - *housing, service users, voluntary agencies*
- Community engagement was much slower than anticipated.
- There was difficulty in sustaining the engagement of a regular person from the community
- There was limited evidence of individual engagement

3.2.3 Strategic planning and procedures

A number of projects did not progress as anticipated and there was a need to be realistic about what was actually achievable within the timeframe with the allocated resources. Feedback from the forum asserted that this was partly associated to the

absence of Psychiatrists involved nationally/locally and not having a centralised coordinated approach to delivery, which should have been considered, to enable delivery of the programme to be more coherent.

Furthermore, the group maintained that a decision should have been made to invest more time for improved outcomes in long term projects, as opposed to going for 'quick wins' and short term gains.

Consideration should have been given to promote mental health conditions with other mainstream services/initiatives, such as mother and toddler groups and linked to world Mental Health Day.

3.2.4 Resources

Representatives asserted that more could have been done with the allocated resources and that responses should have been provided from Commissioners' to ensure that services were appropriate and tailored to meet the needs of the community.

3.2.5 Communication Processes

As a way of enhancing communication, the promotion of hosting more events was regarded as being highly effective to enable communities to do more mental health awareness initiatives.

3.3 The following highlighted what lessons had been learned in pursuit of delivering the DRE programme:

3.3.1 Workforce – Workstreams

- Given that CDWs were regarded as a key component to deliver the DRE programme, their profile needed to be raised and their role clarified at a strategic level.
- Delivery of the programme would have benefitted if there was additional planning around issues related to workforce developments.
- Peer support groups could have been organised where support could have been targeted in particular areas and assisted to eliminate the duplication of delivery.

3.3.2 Partnership Working – Community Engagement Initiatives

- Engagement took longer and was more difficult than anticipated; perhaps a more strategic approach should have been adopted earlier in the process.
- There was a lack of representation from some groups/agencies, perhaps the Board needed to approach/consider how to deliver the remit differently and encourage more voluntary organisations onto the board.
- Psychiatrists were not directly involved at a strategic level, which is a key criteria to implement national policy at a local level; therefore they should have had some links with the board.

3.3.3 Strategic Planning and Procedures

- Delivery of the DRE demonstrated excellent governance processes and a high degree of shared leaning.
- Given some of the challenges in achieving the DRE objectives, it was agreed discussed that these objectives should have been more realistic and managed within a feasible timeframe.

3.3.4 Communication Processes

To improve the dissemination of information, a communication strategy is required to support the implementation of robust communication processes, to assist in raising the profile of the programme.

The strategy should work to ensure that every process has clarity with a focus on equality to encourage all groups to consider the DRE.

3.3.5 How can the positive outcomes be mainstreamed?

The group highlighted the following aspects were necessary to mainstream the initiatives from the DRE:

- To ensure all staff benefit from receiving cultural competency training it should be made mandatory to attend.
- Engage with a wide range of communities.
- Encourage the establishment of peer support groups that can help to: assist individuals to identify gaps in service delivery and to help staff to be integrated into an organisation.
- The new CPA to include other agencies to support BME groups.
- The DRE to be linked to mainstream promotional activity such as world mental health day.
- The DRE should have clear and measureable outcomes with clear reporting lines
- Establish and maintain close strategic links with IAPT

3.4 The following aspects were highlighted as the key achievements:

1. External funding was secured to deliver cultural competency training
2. The Board agreed and produced a multi agency project plan that spanned health, social care, housing and the voluntary sector
3. The Board worked with commissioners to secure additional funds to progress the development of CDWs
4. Recruited 10 whole time CDWs
5. Recruited to post a senior CDW to coordinate the CDW work streams
6. Secured funding from CSIP to develop and deliver a 2 day RECC train the trainers' course. This was in addition to 11 monthly 1 day sessions for anyone in Hertfordshire working in mental health
7. Developed and delivered a clinical trailblazers project to improve the cultural competency of services. This project effectively interfaced with the clinical services
8. Delivered Cultural competency training to 200 staff
9. Trained 20 trainers in cultural competency training across a range of organisations, which included the voluntary sector and the County Council
10. Collated data for analysis to examine how BME communities engaged with mental health and learning disability services
11. The DRE was added as a mandatory aspect of the 'dealing with violence and aggression syllabus.'
12. A number of engagement events were hosted with local BME community groups
13. The Trust experienced an increase in the completion of the number of equality impact assessments
14. Service users were involved in training staff
15. The annual national service user survey had low returns from BME service users, consequently the Board agreed that an annual BME service user survey should be carried out that focused on the specific experiences of BME service users.
16. To identify patterns of inequality within services, the number of incidents has been monitored by the board, particularly related to deaths within services and where restraint is used.
17. The Healthcare Commission completed the race equality reviews and identified that the trust had performed well in implementing the DRE. This success was written up as an example of good practice to be shared across the NHS

4.0 CONCLUSIONS

There were many similarities between the FIS sites. However the key conclusions were:

4.1 Factors Which Worked Well

- 4.1.1 Executive level support greatly helped to progress the projects
- 4.1.2 The recruitment of community development workers gave a significant boost to the various projects
- 4.1.3 Putting community groups and service users at the heart of processes ensured greater sign-up to any changes
- 4.1.4 Joint and partnership working promoted the provision of appropriate and responsive services
- 4.1.5 The early involvement of mental health commissioners ensured service changes were included in subsequent discussions around local service provision
- 4.1.6 The FIS gave new energy to the role-out of training programmes such as “equality and diversity” and “cultural competence”.

4.2 Elements Which Could Have Been Improved

- 4.2.1 Focussed Implementation Sites and other similar projects require dedicated resources to be in place from the outset, this includes project managers, adequate financial resources and other key leads (i.e. CDWs)
- 4.2.2 In order for such large and complex projects to run smoothly and effectively, formal project management methodology should be adopted and utilised
- 4.2.3 A national, targeted and well planned marketing campaign, would have boosted awareness and engagement of a wider group of stakeholders
- 4.2.4 The early engagement of clinicians, in particular psychiatrists, would have helped to explore changes required in key service areas
- 4.2.5 In projects such as FIS a range of methods and channels for effective communication is required. Again this ensured engagement of a wider group of stakeholders

4.3 Lessons Learned

- 4.3.1 The greatest area of learning was the increased understanding between agencies. This included developing a better appreciation of respective values, ways of working and priorities.
- 4.3.2 In order to achieve the required level of engagement and change in such projects a high level of organisational commitment and resources is required
- 4.3.3 The early identification of the role and application of CDWs (and other key personnel) in relation to FIS would have increased the pace of change
- 4.3.4 The setting of achievable and realistic objectives would have helped to avoid frustrations and delays

4.4 Mainstreaming Positive Outcomes

- 4.4.1 Giving equality and diversity and cultural competence training mandatory status would help to mainstream the positive outcomes from FIS

- 4.4.2 A comprehensive review of all relevant policies, procedures and practices would ensure there is a “framework” which supports equality and more specifically race equality in mental health care
- 4.4.3 Agencies involved in FIS and other similar projects should agree a range of rewards and incentives to encourage leadership and champions in this area
- 4.4.4 Work around Race Equality should be embedded in other mainstream initiatives such as “World Mental Health Day”
- 4.4.5 A framework which supports the effective flow of information and data between agencies would greatly help to mainstream positive outcomes

4.5 Recommendations

For future FIS and other similar projects to succeed, the key leads will need to consider the following:

1. FIS and other large multi-agency projects should secure the support of an executive level lead
2. Formal project management methodology, including the setting of achievable objectives, should be utilised from the outset
3. Project objectives should support wider strategic organisational objectives. This will ensure ownership and support from key groups and individuals
4. Community groups, including service users, should be actively engaged and empowered to be at the centre of all initiatives
5. A range of methods and channels for supporting joint working, communication and engaging with a wide group of stakeholders should be explored and agreed from the outset
6. The nature and level of all resources, including finances, personnel should be agreed from the outset. Allocated resources should be commensurate with the products and outcomes planned for.
7. A stakeholder analysis should be completed at an early stage to ensure relevant stakeholders are engaged in an appropriate manner. This includes such groups as clinicians and mental health commissioners
8. Clear roles and responsibilities of all involved should be agreed from the outset
9. Clear processes for review, evaluation and sustaining benefits should be discussed and agreed at an early stage in the project

5.0 APPENDICES

5.1 Bedfordshire and Luton – DRE Project Board

5.1.1 Membership

- Project Sponsor - Paul Mullin, Chief Executive, BLPT
- Project Director - Debbie Dunning, Quality & Governance Director, BLPT
- Project Manager - Anjum Gray, Equality & Diversity Manager, BLPT
- Project Co-ordinator - Jacqui Burnett, Equality & Diversity Lead, Bedfordshire & Hertfordshire SHA
- RDC Director, NIMHE Eastern Region
- Dean Pinnock, Race Equality Lead, NIMHE Eastern Region
- Fay Brown, Director of Social Care, BLPT
- Mike Ringe, Director of Commissioning, Bedford PCT
- Director of Commissioning, Bedfordshire Heartlands PCT
- Director of Commissioning, Luton PCT
- Director of HR & Workforce Development Directorate, Bedfordshire & Hertfordshire SHA
- Charlie McNally, Head of Adult Services, Bedfordshire County Council
- Paul Wiltshire, Supporting People Manager, Luton Borough Council
- Fitzroy Wilson, Unit Manager, Ashanti Project
- PPI Chair, BLPT
- Trevor Adams, Dignity
- Bony Shamalo, Bedfordshire African Community Centre
- Patrick Markland, Community representative from Marsh Farm
- Gurch Randhawa, Director, Health Research Department, University of Luton

5.1.2 Terms of Reference

- To identify and develop strategic and integrated responses to mental health priorities to guide and support partners and stakeholders in the Focused Implementation Site.
- To contribute to improvements to the Mental Health and well being of BME communities and those socially excluded groups in the area by leading and influencing strategic change in local health and social care systems using a whole systems approach.
- To support the implementation of 'Delivering Race Equality in Mental Health Care' and related mental health policy
- To provide more appropriate and responsive services for BME communities
- To monitor and report on progress with regard to implementation of 'Delivering Race Equality in Mental Health Care'
- To consult and negotiate with other relevant agencies including service users on the development of local and regional mental health priorities.

5.1.3 Objectives

- To be a central point for communication and consultation in respect of 'Delivering Race Equality in Mental Health Care' in the SHA region and ensure two-way communication with the National BME Programme Board via the Regional FIS Group.
- To help to identify and articulate BME communities' needs and priorities and ensure that these are reflected in the local FIS work programme and action plans.

- To work with other partners and stakeholders, maximising opportunities to mainstream race equality in mental health care across all age groups.
- To benchmark countywide progress in relation to national policy, identifying significant gaps that exist at present.
- To facilitate the dissemination of positive practices, tools and approaches to support commissioners and providers, both statutory and voluntary, in their efforts to improve mental health care for BME and socially excluded groups, thus promoting social inclusion and recovery. Undertake to disseminate learning locally and regionally as well as nationally through meetings with the National Project Implementation Team (NPIT).
- To influence the training and workforce strategy for the health and social care sector in the area to ensure it addresses issues in relation to BME mental health and cultural competence.
- To facilitate sub-groups, task groups and time-limited interest groups as appropriate to realise these objectives and make links to already established groups as appropriate.
- To develop the capacity of community and voluntary partners to play a proactive role in service planning, provision and delivery.

It is hoped that members will possess some, if not all, of the following:

- A willingness and intention to exert strategic influence within service and/or organisations
- Commitment to real service improvement
- Mandate to attend on behalf of an organisation or group
- Commitment to reporting back and disseminating information
- Access to networks to be able to disseminate and share information
- Skills, knowledge, understanding and commitment in respect of BME Mental Health
- Willingness to learn from others and share own learning skills
- Awareness of the political context and agendas that relate to BME issues
- Willingness to question and challenge

5.1.4 Representation and Diversity

The importance of representation and/or advocacy for particular minority groups and marginalised groups is recognised. It may be necessary to ensure mechanisms are in place to engage and include diverse perspectives linked to FIS priorities.

The overall project will be steered by the Programme Board and the different work streams in the Project Work Plan will be the responsibility of sub-groups.

5.1.5 Principles/Values

- Cover all age groups
- Open partnership working
- Cultural competence
- Improve access and experience
- Quality
- Focus on outcomes
- Include socially excluded groups

5.1.6 Frequency of meetings

Meetings of the Programme Board will be held monthly while the sub-groups will meet as required.

5.1.7 Role of the Chair

The Programme Board will be chaired by the Project Director, an Executive Officer from the local health and social economy, whose role will be to:

- Be a Champion for the FIS
- Support the Project Manager
- Remove any obstacles/barriers experienced in the implementation of the FIS Project Work Plan
- Be the strategic lead and link at a countywide level

5.2 Hertfordshire DRE Project Board

5.2.1 Membership

- HPFT Deputy Chief Executive (Chair)
- PCT's Partnership Commissioning Manager
- JCT Planning & Commissioning Manager
- HPFT Equalities Manager
- CSIP Eastern Equalities Lead
- ACS Equalities Manager
- HPFT Senior Manager
- HCC Senior Manager
- HPFT Senior Community Development Worker for DRE
- Viewpoint
- Carers in Herts
- BME Service User Representation
- Housing Representation

5.2.2 Terms of Reference

- To identify and develop meaningful and relevant responses to mental health priorities to guide and support partners and stakeholders.
- To contribute to improvements to the Mental Health and well being of BME communities and those socially excluded groups in the area by leading and influencing change in local health and social care systems using a whole systems approach
- To support the implementation of 'Delivering Race Equality in Mental Health Care' at a local level.
- To provide more appropriate and responsive Mental Health services for BME communities
- To monitor and report on progress with regard to implementation of 'Delivering Race Equality in Mental Health Care'
- To consult and negotiate with other relevant agencies including service users on the development of local and regional mental health priorities.

5.2.3 Objectives

- To be a focal point for communication and consultation in respect of 'Delivering Race Equality in Mental Health Care' in Hertfordshire and ensure two-way communication with the National BME Programme Board via CSIP.
- To help to identify and articulate BME communities' needs and priorities and ensure that these are reflected in the board's work programme and action plans.
- To work with other partners and stakeholders, maximising opportunities to mainstream race equality in mental health care across all age groups.
- To benchmark countywide progress in relation to national policy, identifying significant gaps in local provision that exist at present.

- To facilitate the dissemination of positive practices, tools and approaches to support commissioners and both statutory and voluntary providers, in their efforts to improve mental health care for BME and socially excluded groups, thus promoting social inclusion and recovery. Undertake to disseminate learning locally.
- To influence the training and workforce strategy for the health and social care sector in the area to ensure it addresses issues in relation to BME mental health and cultural competence.
- To facilitate sub-groups, task groups and time-limited interest groups as appropriate to realise these objectives and make links to already established groups as appropriate.
- To develop the involvement of community and voluntary partners to play a proactive role in service planning, provision and delivery.
- experiences and outcomes for individuals from BME communities using mental health services
- Evaluate and Monitor outcomes of any programmes of work relating to countywide race equality work.
- Oversee the work and progress of Community Development Workers for Race Equality in Herts.

It is hoped that members will possess some, if not all, of the following:

- o A willingness and intention to exert strategic influence within services
- o and/or organisations
- o Commitment to real service improvement
- o Mandate to attend on behalf of an organisation or group
- o Commitment to reporting back and disseminating information
- o Access to networks to be able to disseminate and share information
- o Skills, knowledge, understanding and commitment in respect of BME Mental Health
- o Willingness to learn from others and share own learning skills
- o Awareness of the political context and agendas that relate to BME issues
- o Willingness to question and challenge

5.2.4 Representation and Diversity

The importance of representation and/or advocacy for particular minority groups and marginalised groups is recognised. It may be necessary to ensure mechanisms are in place to engage and include diverse perspectives linked to the project board's priorities.

The overall project will be steered by the Programme Board and the different work streams in the Project Work Plan will be the responsibility of sub-groups.

5.2.5 Principles/Values

- Cover all age groups
- Open partnership working
- Cultural competence
- Improve access and experience
- Quality
- Focus on outcomes
- Include socially excluded groups

5.2.6 Frequency of Meetings

Meetings of the Programme Board will be held on a quarterly basis. Any sub working groups will be convened as and when necessary.

5.2.7 Role of the Chair

The Programme Board will be chaired by the HPFT Deputy Chief Executive, an Executive Officer from the local health and social economy, whose role will be to:

- Be a Champion for the Delivering Race Equality Agenda
- Strive to facilitate the Removal any obstacles/barriers experienced in the implementation of the Project Board's Work Plan
- Be the strategic lead and link at a countywide level

6.0 REFERENCES

6.1 Primary Sources

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