

Submission into the development of North West London (NWL) Clinical Commissioning Groups (CCGs) 2018 Equality Objectives (EO)

Race on the Agenda (ROTA), Council of Somali Organisations (CSO) and their members and networks, Centre for Armenian Information and Advice (CAIA), Tamil Community Centre (TCC), Network of Eritrean Women (NEW), Ilays – Somali Community Organisation, Account Trust (Nepali Community Organisation), National Survivor User Network (NSUN), with contributions from several Member organisations of HEAR - Equality and Human Rights Network, We Coproduce.

This submission response specifically addresses how the eight CCGs in NWL (Ealing, Harrow, Hounslow, Hammersmith & Fulham, Hillingdon, Brent, Kensington & Chelsea, City of Westminster) can use EO and Equality Delivery Systems (EDS) to reduce health and mental health inequalities for BAMER people with mental health (MH) support needs in West London. The eight CCGs in North West London are producing equality objectives and commissioning plans for the next four years. The development and updating of Equality Objectives (EO) and Equality Delivery System (EDS), in consultation with communities of need, is a statutory obligation designed to help CCGs commission and deliver the right services and reduce health inequalities.

We would like to work with NWL to support the eight CCGs to become an example of using these mechanisms and cross-CCG working to produce real, measurable reductions in health inequalities for significantly discriminated against communities.

An area of priority for residents of NWL is better commissioning, procurement and delivery of services for BAMER people with Mental Health (MH) Support Needs across the eight boroughs. Due to the nature of MH delivery within the NHS, a joined-up approach across the region could be an excellent opportunity to demonstrate benefits of working across CCG/borough, and overcoming the lack of understanding of how mental health services are organised, commissioned and delivered by professionals, community leaders and service users alike. Parity of esteem for MH is a priority for the NHS (see ROTAs letter).

This submission is also an example that shows that BAMER and Disabled communities are 'hardly hard to reach' and how genuine involvement is possible when working with the right partners. Below is an outline of the discussions and points raised at the consultation event: "Hardly Hard to Reach: We Are Having Our Say" on 12 June 2018 as well as REAP's Networking Conference: "Building New Lives: Refugees in West London" and outreach within our networks outside those events. Over 50 people from BAMER backgrounds with mental health support needs, BAMER community organisations and local councillors attended the event on June 12. Organisations represented include BME Health Forum, MIND, Healthwatch, Havelock Family Centre, Women and Girls Network, Neighbourly Care, Poles in Need UK, in addition to the signatories of this response.

Concerns About the Development of EO, EDS, and Lack of Community Involvement

The structures, methodology and SMART outcomes of the proposed EOs are unclear so they are difficult to comment on. Proposed SMART EO must be brought to communities for consultation. Each CCG must look at their demography and ensure they consult and engage on that basis. To support the work going forward we would like to see local data on protected characteristics and disadvantaged groups who do not come under the Equality Act and so are not counted as having 'protected characteristics' and use/effectiveness of currently commissioned MH provision provided by each CCG.

Purpose of and Statutory Duties Held Within EO and EDS

EO and EDS cannot just quote policies and practices that are basic legal requirements of CCGs as an employer or public body. Instead EO and EDS must be about active steps to reduce health inequalities in the delivery of NHS services in the CCG area.

EO and the EDS must take the organisation(s) forward and ensure that, year on year, all their work reduces health inequalities in the communities they serve.

EO and EDS are designed to build on the achievements of the past, however, despite multiple requests over the last year the Accountable Officer(s) (AO) never provided copies of the previous EO and EDS. It therefore makes it impossible to contextualise or develop EO that build on previous EDS.

SMART

As EO need to be SMART we are disappointed not to have had more concrete proposals to consider, however, we were encouraged to hear that these will be developed with the communities.

We also welcome that additional, specific local EO will be proposed and adopted within each individual CCG. We look forward to being given an opportunity to consult on local EO.

Attendees at the consultation event welcome the fact that these are only 'proposed' EO. We look forward, therefore, to seeing the next draft, updated in light of contributions from the communities.

Lack of Community Consultation

The lack of clarity on timelines and deadlines for the consultation, the inaccessible and, inappropriate survey (described as a consultation despite including no proposals, questions about barriers or unmet need, and never provided in an accessible version) along with unacceptably few, poorly advertised consultation events (3 for 8 CCGs, covering nearly half a metropolis) allows us to infer that the CCGs, their AOs and Boards did not seriously intend to involve their communities or reduce health inequalities.

It has been brought to our attention, for example, that the consultation event covering Ealing and Hounslow only attracted ten attendants and the event in Hillingdon fewer than ten. We also understand that each of the three consultation events allowed a maximum of only 30 participants for a population of eight boroughs combined.

As per previous correspondence, the way the questions were asked and the format of the online survey cannot provide relevant feedback for the drafting of EO as it does not address any questions about unmet needs and the reliance on online engagement, and lack or reasonable adjustments discriminates against marginalised communities.

For these reasons we are concerned that the CCGs have not collected sufficient and relevant data to feed into their EO.

There is a common assumption that BAMER communities are 'hard to reach'. It is our view that BAMER communities are not hard to reach but are not necessarily reachable in the ways statutory services are currently using. Genuine outreach and engagement will overcome such structural barriers and unconscious biases.

We look forward to the 8 CCGs demonstrating that this is a misplaced assumption, and that we will now see genuine involvement and EO that reflect the needs of those communities, from now on.

We encourage the adoption and roll out of [NSUN's 4Pi National Involvement Standards](#) as per ROTA's campaign ensuring Experts by Experience (EbE) are involved in all stages of mental health service procurement, delivery pathways and mental health policy, and monitoring of practice. Following these standards ensures effective co-production, and improve experiences of services and support.

In order for the CCGs to adopt any new EOs and update the EDS all the points above need to be addressed, and SMART EO properly consulted on.

Current Gaps in Services, Unmet Needs and Barriers to Access

A lack of understanding of how stigma, language and cultural differences impact on BAMER communities' ability to access 'mainstream'¹ services, along with a lack of trust in and fear of statutory services (e.g. Social services take children away, fear of injection, "Mental health services drug people and make them zombies"), combine to leave those people with intersectional needs excluded from the health services they are entitled to (e.g. in many languages there is no word for 'counselling', 'mental health', or concept of 'advocate'). There are not enough well-trained professionals from BAMER backgrounds and mainstream professionals are believed to lack in-depth cultural understanding.

It is important to address the multiple forms of marginalisation faced by BAMER services users and create and understanding of how a broad range of policies such as housing, benefits reform, education, policing impact BAMER mental health and wellbeing. In line with [Kindred Minds Call for Social Justice](#), develop a consideration of gender, class, gender identity, sexual orientation, age, ethnicity, refugee or asylum seeker status and levels of English proficiency.

"There is huge inequality in terms of using publicly available services, BAMER community members need grass-roots level advocacy and cultural sensitive environment in order to use Mental Health services in an effective way"
Neighbourly Care, Health Promoter, Ealing

Community led local VCS are the bridge, and currently provide various services to support access to health services, but are largely unfunded and under incredible pressure.

There is a lack of NHS counselling in community languages. It is costly to pay for interpreters (if available) and less effective than therapy in the native tongue. Current gaps are filled by the private sector, however, these costs are prohibitive to most people who are entitled to services.

GPs as first points of contact need to be accommodating of the communication difficulties that people have both in the fact that mental health problems are often difficult to articulate in the various languages as well as the fact people don't even have enough understanding of their symptoms as there is lack of awareness of MH issues (10 min sessions don't work).

The ways statutory services try to organise communication with the community is often not good enough. Translations are of little use as people may not be literate in their languages and automated phone lines have difficulty coping with accents. Accessible language should be used in all written material.

Language difficulties should be considered as equalities issues and the one size fits all approach should be challenged. BAMER communities are diverse as are their needs.

Direct formal MH interventions do not work for BAMER communities and instead require more subtle, culturally sensitive responses to overcome stigma.

There is a serious lack of appropriate independent advocacy for BAMER people with MH needs across the 8 CCGs, including IMCA/IMHA (Independent Mental Capacity/ Health Advocacy), for which there is a statutory obligation. There is nothing available in Harrow or Brent. The limited generic services (reduced to half a day of Voiceability) is not appropriate for or accessed by BAMER people due to lack of cultural understanding and community language access. Where services do exist, for example the

¹'Mainstream' is in parenthesis in this submission due to discussion on the presumption of the western medical model of psychology and wellbeing being 'mainstream' if the majority of patients who should be accessing services require a more holistic, less clinical approach to managing their mental health e.g. Western counselling is culturally specific not outside culture

out/patients holistic CBA approach in Park Royal Brent, these are not presented to BAMER patients and their right to advocacy is not communicated. Statutory services do not communicate or meet their duty to provide advocacy, instead relying on unfunded VCS advocacy and translation or on family members (which is a breach of privacy, and can cause traumatisation and lack of disclosure resulting in more health crisis).

The little work that seems to take place in terms of enhancing networking seems too often to be isolated initiatives that are not sustained through time. People move on and all the information and the good ideas disappear. These things need to be principle led and based on a wider strategy. BAMER health forums could work but again these are isolated projects that don't seem to come out of a comprehensive engagement strategy.

A lot of mental health issues are either reactive or at least made worse by the lack of practical support and so mental health services need to be holistic and practical issues such as poor housing should be addressed at the same time.

It takes a long time to access services and, there is a lack of, (but a need for) long term support, not short term interventions. There is a need for continuity in support. Along with the stigma of a person identifying as in need of MH support. IAPT and other counselling currently available are too short to deal with MH needs. There are real gaps in MH provision for individuals with moderate needs between mild/low level and crisis/admissions. This is not only a breach in NHS duties to provide services that reduce health inequalities, but also means there are higher hospital admissions, more acute needs, more call on police, DV, A&E, addiction services and safeguarding.

Once people are discharged or are, considered recovered (as soon as they take medication) or are medically stable after being sectioned, they seem to lose all support. There needs to be a transitional period, where people are supported in being weaned off support from social services and getting back into the community. The support provided during this transitional period should be hosted by VCS or BAMER communities.

Shifting Perspectives

In terms of wellbeing and good health management in BAMER communities, it is important to see the family or community as the unit of being, rather than the individualist 'protestant' unit of self. For this reason cross-generational, social projects rather than one-to-one approaches are often more appropriate for many BAMER people with MH needs. A holistic understanding of family and community needs to be developed by statutory services.

In light of the above, the MH needs of 'carers', familial personal assistants (PAs), is overlooked.

There are concerns about the Care Programme Approach, with services and support advertised not communicated or delivered to those who are entitled.

Homelessness has a huge intersection with mental and other health needs and these tend to be overlooked in proposals.

Connections between increasing knife crime, groomed violent crime (gangs, CSE, terrorism) and domestic violence are not considered. Cuts to MH services have led to increased violence, passing the burden onto police, hospitals, schools and prisons.

There is a lack of support for addictions to gambling, alcohol and adultery/unsafe relationships (hard drug addictions are largely a Caucasian symptom). Addictions can be a symptom of mental health support needs that are not being met. Lack of services for survivors of domestic abuse, addiction, and family support mean more crisis in mental health, resulting in higher levels of need and acute services (rather than the ability to manage chronic conditions or have early intervention). A holistic

understanding of MH at the intersection with substance misuse needs to be established. Substance misuse is often a symptom of MH support needs.

Faith, faith groups and faith leaders are crucial in many BAMER communities so their understanding of mental health issues is an important element of engaging the communities in the development of community wide support.

There is a lack of support for newly arrived asylum seekers and other migrants, as well as people with No Recourse to Public Funds (NRPF). There seems to be a misunderstanding amongst health and mental health staff in statutory services that asylum seekers and refugees do not have access to MH service.

Examples of Good Practice

Community organisations often provide safer, more accessible, responsive, efficient and cost effective services, drawing on alternatives to the medical model, that reduce health inequality and play an important role in preventing minor mental health problems from becoming more serious, thereby reducing health crisis, costs to the NHS and Public Health and improving planning of delivery. We ask that you consider commissioning the specialist, holistic services provided by local, user and community-led Voluntary and Community Sector (VCS) for BAMER people with mental health support needs and advocating for the proper funding of the BAMER voluntary sector.

“Social prescribing instead of prescriptions, pleasure instead of pills”
Participant at BAMER Mental Health Equality event, 12th June 2018

Health Connectors REAP

The training and development of health connector roles at the refugee led organisation REAP has been a mechanism to share public health messages, act as advocates, reduce isolation and work in a flexible way that is appropriate for their communities. A number of individuals have gone on to re-train in health and social care roles, thereby increasing the numbers of staff within the NHS/SS who are both culturally and technically qualified.

ROTA's Active Lives, Healthy minds

ROTA partners with the Tamil Community Centre, Account Trust, Ilays and the Network of Eritrean Women on the [Active Lives Healthy Minds](#) project, which aims to improve mental health and the wellbeing of members of the communities and supporting them to increase participation in the development and implementation of relevant mental health and health services in the area.

Basic Counselling Skills Training

ROTA provides [Fundamentals of Counselling training](#) to train people working with their partner organisations to work as Mental Health Outreach Workers in their respective communities. The training has been accredited at Level 3 by the Open College Network. The main objective of the project is to prevent admission to acute mental health services by providing community based mental health and wellbeing support services to members of refugee communities. To this end the training provides basic counselling skills to volunteers providing, mental health outreach workers working in their respective communities. The course is comprised of 12 sessions that build the skills of participants and capacity of their organisation.

Mental Health Outreach Workers at Ilays Somali Group

After the completion of the Fundamentals of Counselling training and as a way of introducing their service to the community, volunteers organised a [coffee morning](#) for Somali women in the area. Women coming together to discuss issues of concern over coffee is nothing new in the community, so the new mental health workers built on this tradition and added a dimension introducing mental health and wellbeing support into the conversations. The coffee mornings run monthly and are attended by a

member of the Hounslow SWAP Team, who when needed can offer support and guidance for both the client and the Mental Health Outreach Workers.

The MH Outreach Workers also provide one-to-one counselling to individuals and families in their communities. The Outreach Workers provide culturally sensitive interventions, all speak multiple community languages and have an intimate understanding of the experiences of Somalis in the UK. The Outreach Workers meet their clients either at Ilays's office in Feltham or Outreach Centre in Hounslow or in their own homes or community centres of other public spaces. The Outreach Workers receive monthly case discussion and group supervision by a Somali psychotherapist in Somali.

The Network of Eritrean Women runs a two-weekly coffee afternoon, where women come together to share experiences, eat lunch, do a traditional coffee morning, but also do physical exercises such as fitness, yoga and drama.

Wellbeing Classes Tamil Community Centre

The Tamil Community Centre is a service user led community organisation that aims to meet the needs of a wide spectrum of the Tamil Community. The TCC currently runs English classes, drop-in service for dealing with practical problems (e.g. filling in forms etc), domestic violence counselling and support, and wellbeing classes such as folk dance classes, Yoga, and chair exercise

These activities reduce isolation, provide a space to build trust, rapport and open up, as well as providing a therapeutic space to be heard, as well as improving physical health and releasing trauma.

Practical English classes at TCC, Ilays and Account Trust

TCC, Ilays and Account Trust run weekly practical English language classes, not only improving people's language skills, but also reducing isolation, improving practical life skills to increase their independence, increased confidence and/or reduced fear to access mental health support.

The above examples of wellbeing projects and activities all create spaces where people feel they can belong, connect and engage at different levels, spaces of regular connection with no fixed agenda (as formalising support can push people back) and build resilience and wellbeing. MH support is often about building confidence and reducing isolation.

The projects and services are all culturally based, non-stigmatising, and holistic at a local community space that is known and trusted, in local languages and provide an opportunity for early intervention. The activities are delivered with the help of trained and supported community volunteers.

Community groups are not known, or acknowledged to be resource. Members of the community who are trained and supported can provide a lot of grass roots support and a linguistically and culturally appropriate service. Currently NHS relies on the third sector doing this work unpaid.

Mental Health First Aid delivered by Council of Somali Organisations

The Council of Somali Organisations (CSO) have in the past organised accredited MH First Aid training for adults and children within Somali communities and will deliver more training in July 2018.

Mind

[The Mother Tongue Counselling Service](#) is personalised to suit the linguistic and cultural needs of Arabic and Farsi (Persian) communities in Kensington & Chelsea, Queens Park and Paddington. The Mother Tongue Counselling Service could be replicated and targeted to areas of high need.

BME Health Forum

The BME Health Forum runs a [multilingual emotional wellbeing project](#) that aims to support BME people who live in Westminster, Kensington & Chelsea and Hammersmith & Fulham and are experiencing emotional difficulties but who are not mental health service users. The project also aims to support organisations working with BME clients by recognising the role these organisations have in maintaining

the mental wellbeing of their clients and by offering training and resources to volunteers and staff members to make this work more sustainable.

Holistic/social prescribing approaches facilitated by advocates or VCS workers, are already delivered by local organisations, but are under increasing financial and other pressures. They give access to communities (by responding to culture, language, opening hours), opportunities for individuals to build trust and disclose needs, and are an avenue for public health messages (reducing crisis).

Peer support through befrienders and mentoring develop the skills and confidence of survivors (helping them find employment and develop other preventive strategies) whilst also engaging those with complex needs or having dips or crisis in their MH.

These approaches have had demonstrable successes and could be rolled out further.

Embedded Outreach

The Mental Health Support, Wellbeing & Prevention (SWAP team) within London Borough of Hounslow is a programme that is co-produced with communities and receives positive reports. More hours and staff are needed, but it is an example of genuine outreach into the spaces where people will be.

'Sage on a park bench' a community elder being visibly and regularly present in a local area and becoming a hub for the wider community, providing advice, advocacy and signposting.

An example of family support is [Total Family Coaching](#), offering bereavement and trauma support, as well as family and parenting counselling in various languages.

OT in Hostels

To help reintegration into communities, reduce health crisis, hospital admissions and help isolated people navigate all the support needed. An example of an OT services is Initial Accommodation (for asylum seekers in NASS support), homeless hostels and other sites.

Questions on Proposed Draft EOs and Suggestions for General and Local EOs

Proposed EO 1: *“The CCG will engage and involve local people, communities and stakeholders (representing the Equality Act 2010 Protected Characteristics) when commissioning, designing and evaluating services throughout the year.”*

First of all, knowing the community is a statutory duty under the Equality Act (2010, Article 149).

Furthermore, it is a statutory obligation to meet the duties under the Equality Act (2010) and the Statutory Public Sector Equality Duty (2011) in service design, commissioning, delivery and access, including the timely publication of Equality Objectives (EO) and Equality Delivery Systems (EDS). Proper and rigorous Equality Impact Assessments should inform decisions around making cuts to services to ensure that BAMER communities are not disproportionately affected. The statutory obligation is to involve not simply consult in timely manner.

Objective 1 left us with many questions: How? How specific for individual CCGs? Which AOs are responsible? What structures and methodology will be used?. Who are the communities (can they be defined e.g. diabetics, ethnicity, eastern Europeans)? What is representation?

There should be payment of time and expenses for the expert contributions of the local, user-led VCS and Experts by Experience for consultations, involvement on boards etc. Training and development should be delivered to all contributing to these processes (both from the VCS and the statutory side)

Proposed local EOs, as well as updating and SMART EOs, EDS for each CCG must be brought to communities for consultation.

Involvement should reflect local demographics.

Proposed EO 2: *“The CCG will continue to provide accessible information and throughout the year will work with patients and carers to develop and test the accessibility of information.”*

How do you define accessible? Accessible communications EO needs to be more specific. All communications should be in plain English as standard. Communication should be available in large print, community languages, BSL, and easily read. Reasonable adjustments are a statutory duty, so, as CCGs know the community of people with health needs WILL contain a high proportioned of Disabled people they must be compliant. Publicity must include genuine outreach to the diverse communities of the 8 CCGs. There should be training for all frontline/gatekeepers on reasonable adjustments and accessible communications, improve access to interpreters when required.

There must be a commitment not to rely on online communications that exclude many marginalised people (race, faith, age, disabled, poverty). Only having information, referrals, consultations etc., online (or directing people online), therefore breaches the Public Sector Equality Duty (PSED). There are also considerable concerns about privacy and therefore lack of disclosure and engagement resulting in health crisis but NHS moving online.

Face to face networking is crucial.

Accessibility and equalities should be an internal standard.

Design accessible application processes, contracts and commissioning to harness the expertise and networks of local, BAMER and user-led VCS organisations to provide holistic services, reach grassroots and to deliver specific programmes and projects to support CCGs in their obligation to reduce health inequalities.

Proposed EO 3: *"The CCG will demonstrate- and report in the annual report each year- it is a fair and inclusive employer that recognises the value of diversity."*

What does this mean? Will this be reflective of local area? How will the CCG demonstrate this? Stats reporting not enough, how does this relate to local context? What happens within each service? Should record all protected characteristics (and PNS) for all staff and applicants including details of different structures, roles and bands/management. How will the CCGs improve fairness and inclusivity? Meeting legal employment duties and producing an annual review are not objectives but basis principles of running an organisation. How do the CCGs recognise the value of diversity?

CCGs should focus on employment, training, retention and promotion policies and procedures. Using local members for training and within 4Pi to consider role requirements, recruitment processes and potentially sit on interview panels.

Upskilling community workers and focused recruitment to improve employment to counselling, GPs, advocates, outreach workers etc., to diversify employment and meet needs of the communities you serve (e.g. desirable role requirement to speak specific community languages).

We would like to see a SMART EO that requires that the recruitment of senior policy makers and commissioners reflects the communities for whom they work, as knowledge of local communities would be a basic requirement of the role.

Proposed EO 4: *"The CCG will continue to embed equality and diversity principles by developing and supporting all staff and Governing Body members to promote and champion inclusion in all aspects of the CCGs work."*

We are extremely worried by the statement of 'continue to embed' when the CCGs currently do not meet the most basic equalities duties in delivery, commissioning or involvement. At the consultation event arranged on behalf of the CCGs - a first consultation with BAMER communities - none of the information presented by the CCG was in plain English and the survey, previous EO and EDS, SMART proposals, consultation dates, deadlines and timescales were not provided (despite having had ongoing requests to the AOs in the 8 CCGs for year+). Continuing, therefore, in this vein will mean the CCGs will continue to breach equalities duties and the AO embedding practices that do not meet the CCG duties. Also, this is a statutory obligation and therefore it is worrying to see it phrased as an EO.

The Governing Body of each CCG, in order to promote and champion inclusion, must be trained by local user-led experts to better understand the current context, the law and their obligations as public servants and/or Board members. How is the data recorded to monitor this and the other EOs? BAMER/ other/ Black African? We want our diversity recorded, measured and truly reflective of the actual communities. It is impossible to meet any EO without real data.

Implementation and monitoring is key and this should also be transparent.

EOs should be live and updated regularly in reflection to monitoring outcomes

Suggested SMART EO for NWL and 8 CCGs

Working Together

Contributors appreciate some MH services and obligations relating to need, are the responsibility of not just CCGs but Local Authority (LA) and public health (for example, the overlaps with IMHA duties and advocates required in Care Act assessments). CCGs and LA must work collaboratively to develop seamless provision for people with rights and complex needs.

A specific commitment to deliver joint/dovetailed appropriate independent advocacy for BAMER MH users/disabled people (in JSNA and other strategic cross-stakeholder mechanisms) should be a priority.

4Pi around mental health support needs and BAMER communities to oversee entire process of commissioning, procurement and delivery. LB Hounslow signed up, others across the boroughs and implement.

We would like to see a commitment to provide appropriate holistic services for the communities. CCGs priorities (e.g. housing, children's services, community safety, maternity and parenting, immigration/Home Office (HO), job centres/DWP, all impact on BAMER individuals ability to manage their health and wellbeing)

Training NHS Staff

Cultural training should be bought in for staff (therapists, commissioners, GPs, frontline/gatekeepers) from local VCS highlighting specific local needs and barriers. A focus on established BAMER communities and new arrivals could be included. This happens for harmful practices why not MH, as also safeguarding responsibilities.

SMARTing Up

We would like to see a commitment to commissioning culturally appropriate provision of MH services for BAMER communities in line with CCG demography, providing appropriate, sustainable services for my BAMER constituents with mental health support needs.

Commitment to commissioning early intervention, holistic services from the local VCS that enable people to manage their mental wellbeing, reduce health crisis and costs on the NHS (and aiding CCGs meet STP goals), aid future planning of services and disseminate public health messages. There is a tendency to assume that voluntary, community-led and user-led groups' role is limited to preventative work and to input when people leave secondary care, however, we want to point at the role VCS can also play in providing alternatives to detention.

There is a need to financially support the hubs/day centres/premises of local user-led VCS. Marginalised people and communities often use these as their first or only port of call.

Monitoring whether service providers are connected with the demographic of the communities, and make responses to communities a key performance indicator (KPI), that can be outsourced (if fully funded, as currently statutory, nationals and generic services 'use' the reach of frontline VCS in reporting, but do not pass on benefits, thereby capacity draining as well as stealing intellectual property).

Meeting Duties and Protecting Children and Vulnerable Adults

As well as commissioning services for the communities and having safeguarding responsibilities as part of that design and delivery, statutory services also have duties to not put vulnerable people at risk. Lack of crèche facilities and a reliance on children as interpreters and advocates unacceptable and breaches the right to privacy, health and can traumatise young people. CCGs need to commit to children never being expected to take on statutory obligations around access and advocacy.

There is a need for after school clubs, facilitated by Experts by Experience and user-led local VCS, that discuss mental health, grooming, online safety, knife crime as well as keeping young people busy.

CCGs should consider intersectional inequalities and the demography of the communities that they serve when commissioning (e.g. BAMER women and domestic abuse, BAMER men and addiction), including people who experience inter-sectional abuse as adults/elders.

GPs are a point of referral, and therefore CCGs must work with them to better understand their duties to disabled people (including people with MH needs) BAMER communities and other equality streams. Commissioning training for GPs, receptionists, and nurse practitioners is vital. Buying VCS to do outreach in surgeries could also help overcome barriers and help GPs meet their obligations.

Innovative, Equalities-led Commissioning

Through joined-up thinking a lot of these small BAMER-led initiatives and services could be pulled together, better organised, and properly resourced with maximum impact. There is a need for someone embedded, who knows all the services.

Several participants at the consultation meeting asked: Where is the aspiration? The new direction? The current objectives are 'business as usual'.

Funding is often allocated to 2nd tier organisations (prioritised because they are able to respond to consultations/ attend meetings) but the frontline VCS are left out of commissioning opportunities and are continually under-funded, despite their impact on and access to service users. There seems to be a need to address the fairness of the tender process, with the seemingly preferential treatment of big VSCs who are working with commissioners on local involvement so are in a position of accessing more information than other small groups who compete against them. CCGs should add clauses to contracts awarded to national, generic and second tier organisations that require them to sub-contract/buy expertise from local, user-led VCS to KPI related to specific communities, inequalities or conditions (these should be designed and monitored with EbE as per 4Pi).

NWL should commission advocacy, training and community appropriate services from the local, user-led VCS. Monitoring of uptake on the basis of equalities will show if 'mainstream' are getting to the communities of need.

Quality over quantity. Rather than reflecting good practice, when reducing health inequalities and working with people with complex and long-term needs the numbers 'going through' a service do not necessarily indicate good practice. Instead these numbers can demonstrate a non-responsive 'non-service'. CCGs using 4Pi and working with EbE and the local VCS can design better ways of measuring impact of services. Understanding the importance of qualitative case-studies as reporting should be internalised as beneficial in CCGs.

In order to measure success and see contributions to sustainability and transformation partnerships (STPs) etc., all services must be able to compare their work to the costs of hospital admissions, crisis interventions, police services, prisons, as well as in light of mortality, disability, and mobility rates. NHS and statutory bodies must share data on and costs of crisis/ acute admissions so that services are able to bid on even playing field. Therefore we request making core NWL cost data available so that cost benefit analysis can be undertaken by VCS when relating their cost per head to cost of accessing beds or emergency services (broken down by access by demographics).

Pilots, when used to move from a medical model and to create and evidence new contemporary models that are being tested that really impacts the community, should be locally led by people on the ground. Local user-led VCS, who have been delivering work for their communities for many years, generally know what works, and have evidence of need (when funding is available to gather this information), impact and feedback loops in their work. As most people with health needs require consistent and sustainable services, further funding should be made available to continue the work



tested through a pilot. Otherwise pilots may risk being cost ineffective, wasting limited capacity and producing poor results As per ROTA's letter we would like to see the 8 CCGs respect the skills, expertise and knowledge of local, user-led VCS and fund and pay them appropriately.

Mental Health Equality Campaign

In early May, ROTA and HEAR Network with VCS partners and BAMER people with mental health support needs launched a mental health equality campaign. 120 London Councillors and VCS workers (38 Councillors across a number of London Boroughs) signed up in a matter of weeks. We would like to see more CCGs commit to the six points of the campaign, which have been integrated into this response. We encourage CCGs workers, AOs and Boards to sign up to [ROTA's letter](#).