**EMHIP Working Group Two**

**Wednesday 2nd November 2020 2:00pm-3:30pm**

**Online via Microsoft Teams**

**Minutes**

**Present:**

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| MG | Malik Gul | Wandsworth Community Empowerment Network |
| GD | Gemma Dawson | NHS South West London CCG |
| GM | Geetha Maheshwaran | Shree Ghanapathy Temple |
| RM | Ruth McKinney | Wandsworth Community Empowerment Network |
| SB | Sahar Beg | Mindworks UK |
| MH | Martin Haddon | Healthwatch Wandsworth |
| SS | Professor Sashi Sashidharan | Consultant to the EMHIP Project |
| MR | Mark Robertson | NHS South West London CCG |
| CH | Charlotte Harrison | SWLSTG Mental Health MHS Trust |
| JS | Nuwan Dissanayaka | Leeds & York Partnership NHS Foundation Trust |
| KO | Kalu Obuka | NHS South West London CCG |
| MW | Michelle Woodward | NHS South West London CCG |

**Apologies:**

**Glossary:**

EMHIP – Ethnicity & Mental Health Improvement Project

WG – Working Group

CMHT – Community Mental Health Team

SMI – Serious Mental Illness

AOT – Assertive Outreach Team

KI Report – Key Intervention Report - [EMHIP\Ethnicity & Mental Health Improvement Project Report Final.pdf](http://wcen.co.uk/wp-content/uploads/2021/01/Ethnicity-Mental-Health-Improvement-Project-Report-Final.pdf)

SWLSTG – South West London & St. George’s Mental Health NHS Trust

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| **Agenda Item** | **Minutes** | **Actions and Papers** |
| **Welcome and introduction** | MG welcomes the group and gives a brief background to the Ethnicity and Mental Health Improvement Project (EMHIP) and the reason/need for this work. He introduces GD, Head of Strategy and Projects (Merton & Wandsworth) NHS South West London CCG who is providing Project Management support for the EMHIP Programme.  Everyone on the call introduces themselves. | EMHIP website[www.emhip.co.uk](http://www.emhip.co.uk) |
| **Membership and way of working** | MG points to the Core Principles and Ground Rules that were sent out prior to the meeting. GD informs the group she will be recording it.  MG sees this WG as agreeing a timescale for this work (6-8 weeks) and to agree a project specification and business case for the mental health and wellbeing hubs that can be taken back to the commissioners. He talks to the diversity and value of this group. | [EMHIP\Ground rules starter for ten.docx](http://wcen.co.uk/wp-content/uploads/2021/01/Ground-rules-starter-for-ten.docx) |
| **Scene Setting** | MG introduces SS (Project Consultant) SS sets out the purpose of this WG and its 3 core principles   * Creating options for patients & patient autonomy * Embedding services in the community as critical partners, and changing the centre of gravity * Creating a culture of care, away from coercion   This WG covers a broad range of interventions covering the crisis and acute care pathways. It involves introducing 2 new services to SW London as an alternative to Hospitalisation: crisis houses and a family placement scheme. The focus of this work is on young Black men and South Asian women and is supported by local BME communities.  The care in a crisis house will involve the same level of care as in acute care and run by people in the community alongside the Trust.  The average stay in a family placement is lower than in inpatient care, and relationships can develop helping to prevent readmission. The host family will have training and 24/7 care and help available.  Another aspect to this work is those with long-term SMI who are usually with complex needs and CMHT services, and within these two groups: the first being those with long-term diagnosis with long periods of illness, compliant with medications but with no real rehabilitation work taking place in the long term.  The second group are usually young black men coming in via Mental Health Act with a history of involvement with the Criminal Justice system who try to get away from services as quickly as they can as they do not see it as appropriate to their needs. There is then no real attempt to stop readmission. Assertive Outreach works particularly well with BME communities as it works at reintegration into the community and alongside their needs. This is a very researched method.  This WG will focus on 4 key components:   * Crisis Houses * Crisis Family Placements * Bespoke BME specific SMI Team * Assertive Outreach Team   CH reflects on the rehabilitation services SWLSTG used to have. More work is being done now in SW London. This work will help us redeliver the services that have been lost and will be beneficial to the whole system as well as individuals. SB agrees, especially the family placement scheme and the whole system approach.  MH questions the scale of this work and whether the community rehabilitation service is a separate service or part of the CMHTs? SS responds that the rehabilitation service is best delivered alongside service providers. Community integration part is best alongside community partners. The Assertive Outreach Team is professionally driven but with an ethos of giving people their lives back with a protective arm around them through the service.  ND comments on assertive outreach and its long history. He talks about the aligned holistic issues that they help people with and the various external teams they work with. They do use Community Treatment Orders as it is the least restrictive option, and this has helped reduce bed stays.  GM talks of the frustration of family members being excluded from treatment and decisions when caring for family members. Excited about the family placement scheme in helping to reduce stigma and act as a support network and financial gains. |  |
| **Key Tasks** | The group are asked about their priorities. Family Placement has been popular so far. What are the groups preferences/ priorities? All the areas will be put into action, but the work needs to be phased.  SS reminds the group to think about which area is most needed, and this will be determined on the data. Also, to think about the scale, complexity, and impact (criteria)  MR mentions the need for wider support for the crisis alternatives and so this could be a system priority. More time may be taken over the AOT as the cost is much higher. He talks on the complexity of seeing cost savings.  CH mentions the Trust’s Community Rehab Teams. She would prioritise the family placement model and building up a community rehab team. There are SWLSTG teams that could fit in with the AOT.  ND highlights that the priorities need to be locally focused. Priorities will align with the system needs too e.g., if there is a need to reduce detentions, then there needs to be a focus on AOT. He also reflects that many people stay in hospital as there are not adequate homes for them to be discharged to, and this project can help address this.  MG is confident existing BME networks in Wandsworth can find suitable host families. There is conversation about the representation of BME people in services.  KO highlights the expertise in the group and is excited to see the interventions that come out of it. He sees the support for culturally appropriate crisis care and wants to see the clinical input set out to address this.  Family Placement has been identified as a priority with this group. There is understanding that this is a package, and it all needs to be addressed together, especially as each component will save the service money. But practically, it needs to be phased. SS speaks further to the costs of the project and will create a matrix for the next meeting and to work towards a project specification and business case.  Wider conversations will happen in parallel to this WG. Work to be in supporting the wider community partners. | Setting up conversations with other service teams (Victoria Hill and Ricky Dalton)  SS to create a matrix to share |
| **Date of the next Meeting** | MG suggests two meetings a month. MG asks the group to reflect on this. | GD to send round |