**EMHIP Working Group Three**

**Wednesday 3rd December 2020 10:00am-11:30am**

**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 |
| NP | Nathaniel Pamah | Community Activist |
| RM | Ruth McKinney | Wandsworth Community Empowerment Network |
| CD | Dr Carlis Douglas | Hope Atrium |
| PB | Paul Brewer | Soundminds |
| SS | Professor Sashi Sashidharan | Consultant to the EMHIP Project |
| MR | Mark Robertson | NHS South West London CCG |
| BW | Becca Walker | Richmond & Wandsworth Borough Councils |
| BB | Beverly Baldwin | South West London & St. Georges Mental Health NHS Trust |
| CM | Caroline McDonald | Richmond & Wandsworth Borough Councils |
| DN | David Ndegwa | South West London & Maudsley Mental Health Trust |
| AR | Alison Roberts | NHS South West London CCG |
| FN | Fiona Nicholson | Churches Network for Family Care, SWLSTG |

**Apologies:** Cavendish Group

**Glossary:**

EMHIP – Ethnicity & Mental Health Improvement Project

WG – Working Group

AMHP – Approved Mental Health Professional

PCP – Primary Care Plus

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. | [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 gives a background to WG3 – Reduce restrictive and coercive practices and enhance inpatient care. This WG focuses on Key Interventions 3 and 4 of the 5 interventions set out in the KI report.  MG introduces SS who gives a detailed explanation of the purpose of this WG, and about the interventions it focuses on. EMHIP is a specific BME Project and owned by the community.  This WG is concerned with Inpatient Care – this is the real cutting edge of inequalities. If we can get this right, then it would be a big victory.  There are two main aspects of this work:   * Reducing coercion * Enhancing overall experience   SS proposes that there is family involvement throughout the whole process of inpatient care, including in risk assessments to be able to make it more appropriate to the individual. There will be a nominated Person Scheme. Decisions are often made in crisis situations, so having a person who knows the patient there can give a bigger picture. This needs to be internalised and will impact on the clinical interface.  MG welcomes PB who explains the work of Soundminds and Canerows, and the impact this has on inpatient care. MG comments that this work needs to be scaled up and built upon in the EMHIP Project.  This work will include befriending, peer support workers, advocacy and patient/family involvement in decision making processes. This work has never been attempted on this scale before.  MG responds that a lot of this work is what BME communities have been hoping for and promised for a long time  PB asks how EMHIP will cross over and link with other projects, both in the system and community. MG responds that this WG is a holding space and there will be parallel conversations with other related groups. It is a huge challenge ensuring that everyone is joined up and the work is embedded, but that is the ambition.  MG explains that the CCG system now holds EMHIP, with the new Locality Director as Responsible Officer and the ‘owner’ of the Project in SWLTG being Charlotte Harrison, Medical Director.  PB responds that this is exciting but has a few concerns. He explains that the value of Soundminds is not that it is a BME service per se, but that it sits outside the Trust and therefore able to act authentically and independently . Also, he asks about the value of the nominated person being there at all times – for example if there was a crisis in the middle of the night, or if they do not know the patient very well. He talks about the value of Early Interventions Teams being more valuable in getting people on board rather than crisis teams. For 'frequent flyers' we could use 'advanced directives' to pre-identify people to be involved if sectioning is possible  NP contributes about the crisis link with prevention and the value of the Soundminds model. He asks how do you identify the best person to help? Will the advocate get the support and training to help, before, during and after?  SS responds that this is a start, and we are not expecting everything to work straight away. 3rd party involvement may not work in each case, but can in many, for example in repeat admissions. The challenge is changing the system from behind closed doors to make it transparent – can be seen to be challenging the professional’s decisions.  CM mentions conversations earlier in the pathway with Police, A&E etc. FN talks about where people present to services, data and evidence. BB responds about the data held around the interfaces, but not coercion data, but this is being addressed.  CD raises the mistrust that BME communities have of services, and they are ignoring assets in the community who are experts in culture and the individuals. There is a concern that having an advocate can be problematic and have a negative impact on their relationship, and the patient may not want family with them. This reflects the tensions AMHP’s report.  MG introduces DN who talks about the conflict resolution service and the intervention in Lambeth. MR responds on the need to ensure this work is really entwined in all areas and has tangible touchpoints (Soundminds, Canerows, advocacy, AMHP, PCP etc.)  SS summarises that this work is complex but not complicated and driven by values, principles and metrics (control and culture change) | [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) |
| **Key Tasks** | PB highlights the need to iron out the details. GD introduces the needs to identify priorities and phasing. She proposes a different take in which the actions are exploring existing data on when and why coercive behaviour happens. Then a mapping exercise on understanding existing transformation plans already in practice. PB warns against institutional inertia and loss of momentum. He also suggests consulting Acute Care Forums and having service user involvement in the WGs.  Which process will have the best outcomes? MR agrees we don’t want barriers and want to move forward quickly.  SS responds that this work started a long time ago and was based on data, we don’t need to go back for more data as this will just delay. SS will create a matrix for impact/ priority etc. for the next meeting | SS to produce and share a matrix |
| **Date of the next Meeting** | MG suggests two meetings a month. GD asks the group to reflect on this and she will circulate future dates. | GD to confirm dates and send round |