**EMHIP Working Group Three**

**Thursday 7th January 2021 9:30am-11:00am**

**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 , & SWLSTG |
| RM | Ruth McKinney | Wandsworth Community Empowerment Network |
| SS | Professor Sashi Sashidharan | Consultant to the EMHIP Project |
| MR | Mark Robertson | NHS South West London CCG |
| BB | Beverly Baldwin | South West London & St. Georges Mental Health NHS Trust |
| CM | Caroline McDonald | Richmond & Wandsworth Borough Councils |
| DN | David Ndegwa | South London & Maudsley Mental Health Trust |
| FN | Fiona Nicholson | Churches Network for Family Care, & SWLSTG |
| SR | Sarah Rae | Cavendish Square Group- Safety in Mental Health Settings Project |
| KP | Kenneth Phillips | Richmond & Wandsworth Borough Councils |
| V | Vincenzo Spaccapieta | Former - Trieste |

**Apologies:** Paul Brewer, Sound Minds.

**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 & GD welcome the group and recap the last meeting, and introduce the purpose of this meeting- to look at the interventions against the matrix – complexity, impact & cost. This is about phasing and sequencing implementation, not ranking, or choosing between initiatives.  Everyone on the call introduces themselves. |  |
| **Matrix** | SS talks through the matrix and the focus of this WG on reducing coercion and enhancing inpatient care for BME communities. He talks about the complexity and uniqueness of EMHIP, so the need for it to be phased in. What is going to have the most impact on BME inequalities?  Evaluation of implementations will begin in April and we can modify interventions as we go on. The Pilot phase is looking to last around 2 years.  This WG focuses on:   * Reducing coercion. This has 2 elements: coercion in admissions under the MHA and reducing restrictive practices in inpatient care for BME communities. * Enhancing inpatient care. This builds upon existing work of Soundminds and expanding this including the involvement of a ‘nominated person’ in the care pathway and decision making.   MG informs the group that will use the time we have together to discuss the interventions, and asks that the group go away, reflect on this and email comments back ahead of the next meeting.  DN talks on acute MH settings around the UK and the number of components and guidelines involved. What lessons can be learnt, or practices can be adopted? The patient needs to be empowered and their experience improved so coercive readmission is less likely. MG is conscious that we don’t want to reinvent the wheel but rather enhance what is going on to focus on BME communities.  SR talks about the Cavendish Square Group. There is not consistency of care across Boroughs. She reflects on shared decision-making and how they trained staff & SUs in meaningful shared decision making. MG responds with the important correlations with cultural competency.  FN believes there should be a more trauma informed care approach in SWLSTG. Some of the first training is how to restrain – should we introduce decision making training here too? There is room and need for this training across the bands. There are some people that want to be in inpatient care, but here we are talking about those who don’t want to be there. There needs to be a section in their notes on what they want their journey to look like.  MG talks on the importance of writing down protocols, especially working with BME communities. SS clarifies what shared decision-making means in this context – currently it is clinicians and social workers making decisions based on risk assessments. They are meant to liaise with family but often don’t as in crisis. We need to challenge this practice. There is ‘relentless negotiation’ in the Trieste model.  MG notes that the spaces where risk decision are being made are consultant’s sacred spaces and changing this will involve a huge culture change. We need to reflect on how to do this with SWLSTG.  CM talks on role of AMHPs and the distinction between planned and crisis assessments and where there are discussions with family. Relationships in families may be broken. How do we get in earlier and work with the CMHTs? She talks on the issues of risk– what are the alternatives to going into hospital? Is there a role for more formal advocacy for those without people around them to act as a nominated person? MG responds with the 5 EMHIP KI’s.  NP refers back to his work as a recovery support worker and the good work of Soundminds. There needs to be payment and training for the nominated person to compensate for the time needed. There needs to be humility from professionals, they are trained, but not culturally aware. MG speaks to the importance of paying people and getting money out of institutions and into the community – a fairer distribution of resources.  DN talks about systems – managing people in the community with home treatment teams to avoid hospital admissions. He talks about action plans that are made after the first admission, but this doesn’t affect the first admission which can shape a person’s view.  VS reflects on the belief that if you have restrictive practices then the more you believe they are necessary. In Trieste they don’t want aggression, nor a patient without a voice. There are conversations at the beginning of pathway and in early intervention.  SR refers to the Open Dialogue Approach in Finland. She suggests the group get a working definition/understanding of shared decision making.  MR sees this work as being at the centre of where the biggest impact will be for BME communities. This is about the change within statutory organisations and tackling it within legal frameworks. SU & Carers to be on board too as well as staff. SWLSTG are redesigning the Wards and there are opportunities to think about seclusion rooms etc. | [Matrix](http://wcen.co.uk/wp-content/uploads/2021/01/EMHIP-Working-Group-3-Matrix-December-2020.docx) |
| **Next Steps** | The WG are asked to read the KI Report and matrix and get back to GD with any comments.  GD looks forward to developing a skeleton project plan and set up a sketch of what this high-level plan to complement what is already happening in the system.  Who holds the golden thread for this work and linking with all relevant interventions outside EMHIP? BB suggests introducing a risk register alongside this project.  KP comments on the importance on including current as well as ‘regular’ SU&C involvement throughout all EMHIP groups. EMHIP doesn’t want token representation. BB has a diverse group of SUs in their involvement team and recommends we link with them (Vanessa Cummings and Vanessa Robinson).  NP talks on the importance of collaboration and not prescription. Lots of BME people don’t want to engage with the NHS and so Soundminds, Community involvement etc. is vitally important. He asks about a timeframe for project. | [KI report](http://wcen.co.uk/wp-content/uploads/2021/01/Ethnicity-Mental-Health-Improvement-Project-Report-Final.pdf) |
| **Date of the next Meeting** | 20th January 2021  2:00pm-3:30pm  Apologies to: Gemma Dawson |  |