RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

AMHE
Advancing Mental Health Equality

Advancing Mental Health Equality Collaborative

Learning Set 2

26th November 2021 10:00 – 12:00

Welcome!

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Housekeeping

- Please mute your microphone unless you are speaking.
- If you would like to ask a question or leave a comment, please use the chat function within the meeting.
- The session will be recorded and shared on our website. If following today's event you do not wish to be identified please contact us on the email below.
- If you experience any technical difficulties, please email AMHE@rcpsych.ac.uk

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Agenda

Time	Item	Speaker
10:00 – 10:05	Welcome and introductions	Tom Ayers
10:05 – 10:20	Identifying Populations	Uju Ugochukwu and Helen Smith, Norfolk and Suffolk NHS Foundation Trust
10:20 – 10:35	Embedding Community Voices: AMHE	Pennine Care NHS Foundation Trust
10:35 – 11:05	Panel Discussion: Reflections on Populations **Laura-Louise Arundell** - NCCMH **Mark Farmer** - NCCMH **Raj Mohan** – South London and Maudsley NHS Foundation Trust **Lade Smith** - NCCMH	Tom Ayers
11:05 – 11:15	Co-production and breakout task	Mark Farmer
11:55 – 12:00	Close – next steps	

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Advancing Mental Health Equality at NSFT

Dr Uju Ugochukwu

Consultant Psychiatrist, Medical Director for Quality, Quality Improvement Coach

Helen Smith

Quality Improvement Coach

NHS
Norfolk and Suffolk
NHS Foundation Trust

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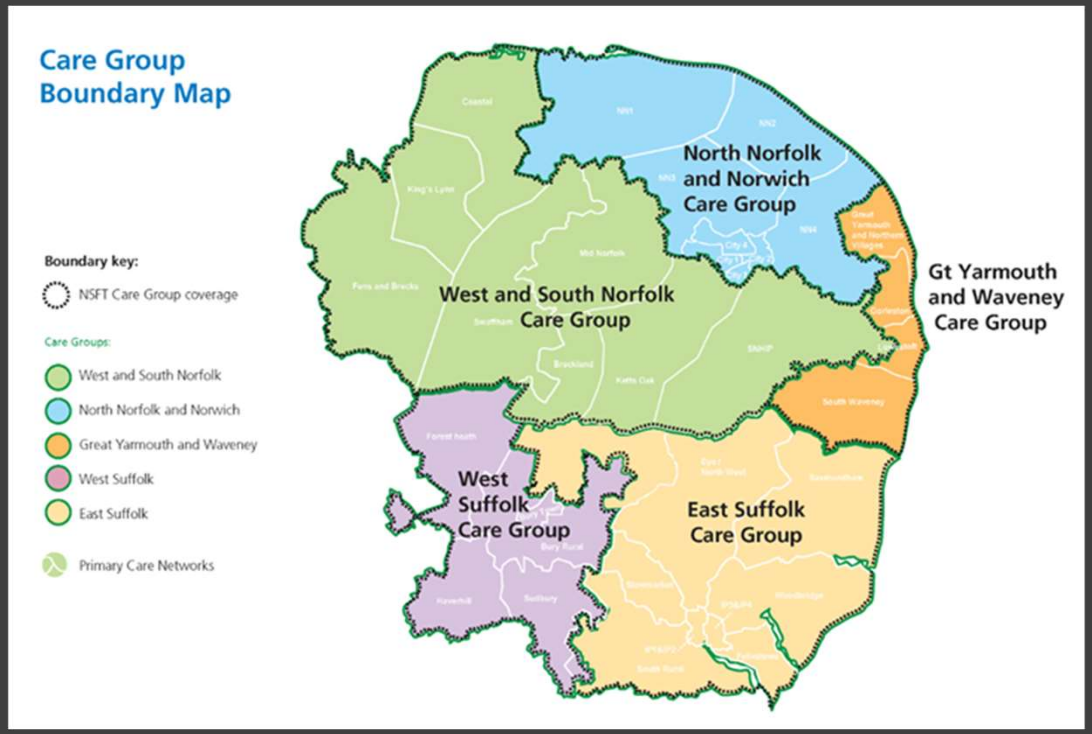
About us at Norfolk and Suffolk Foundation Trust



Population: 1.6 million

Wellbeing service

Secondary mental health services: Inpatient and community services for all ages

Staff: 4,000

The journey so far

Publicising AMHE

Your news this week

Tackling inequalities to improve care

« Previous article Next article »

Tackling inequalities to improve care

Dr Uju Ugochukwu, Consultant Psychiatrist and Medical Director for Quality

Our Trust has launched a far-reaching quality improvement (QI) project which aims to reduce health inequalities so that everyone can get equal access to mental healthcare and improved experiences and outcomes.

Called Advancing Mental Health Equality (AMHE), the initiative will bring together staff and service users from across the Trust, together with community groups and partner agencies.

More in this section

Tackling inequalities to improve care

Equal access to mental healthcare and improved experiences for all

Praise for Great Yarmouth team as waiting lists reduce

Recruitment success and improved assessment process helps team better support service users.

Hear from colleagues involved in QI

How can you think in the QI way?

Tweets by @NSFTtweets

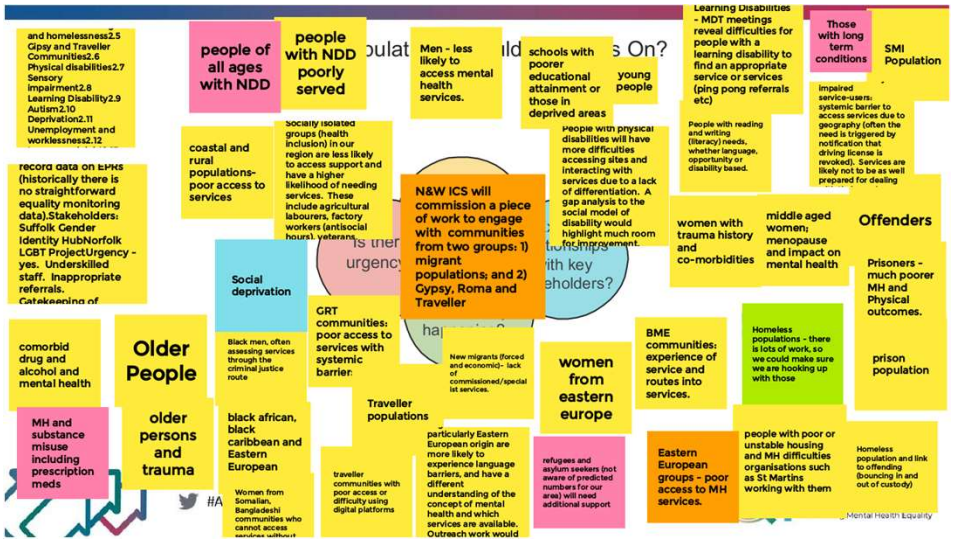
NSFT mental health @NSFTtweets

Replying to @NSFTtweets

We're pleased to say now 75% of staff have had training & the final 25% booked in, we can open the ward to new admissions from Thurs 25 November. Our priority will be to move any patients

Overarching Project Group

- Senior People Participation Lead
- 2 service users/experts by experience
- Medical Director for Quality
- Quality Improvement Coach – NSFT
- Senior Lecturer at UEA with interest in inequalities
- Head of Research
- Director of Communications
- 3 GP Clinical Leads/Inequalities Lead
- Head of Employee Experience
- Equality Diversity and Inclusion Lead
- Quality Improvement Coach – RCPsych
- Chief Medical Officer (sponsor)
- Others



First AMHE meeting – Sept 2021

Populations

- Black Asian and minority groups (including eastern Europeans)
- Forced migrants, refugees and asylum seekers
- Gypsy, migrants and traveler communities
- Offenders and prisoner population
- LGBTQ+
- Men from BME backgrounds
- People with neurodevelopmental disorders
- Homeless population
- Older people
- Young people
- Men
- People who use drugs and alcohol
- Long term conditions
- People with learning disabilities
- Socially isolated and agricultural workers
- Social and economic deprivation

Second meeting

Jamboard exercise focused on the 4 questions

Structured conversation

Remove some of groups – intersectionality

Requested data

Black, Asian and minority ethnic groups

Is there urgency?

People from black-African and Caribbean communities are 40% more likely than white-British people to come into contact with mental health services through the criminal justice system

BME communities: poor experience of service and routes into services.

Women from Somalian, Bangladeshi communities who cannot access services without family.

Many black-African and Caribbean people, particularly men, do not have access to psychological treatment at an early stage of their mental health problem

Some people from BAME groups mistrust mental health services based on negative experiences

Black adults are more likely than adults in other ethnic groups to have been detained under a section of the Mental Health Act

black-British men being overrepresented in mental health secure care

Black, Asian and minority ethnic (BAME) individuals reporting poor levels of satisfaction with community mental health services compared to white-British counterparts

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Is there any work already happening?

Bonnie - Barriers and facilitators for user involvement for ethnic minority service users

Bonnie - Developing a conceptual framework for the relationship between systemic barriers, stigma and help-seeking in key ethnic minority groups in EoE

Bonnie - Concepts of psychosis in Afro-Caribbean groups and links to help-seeking

Bonnie - how can we engage south asians in mental health services

Mental health Impact of community-strengths intervention in UK South Asian communities (In development)

Is data available?

Existing relationships with key stakeholders?

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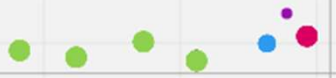
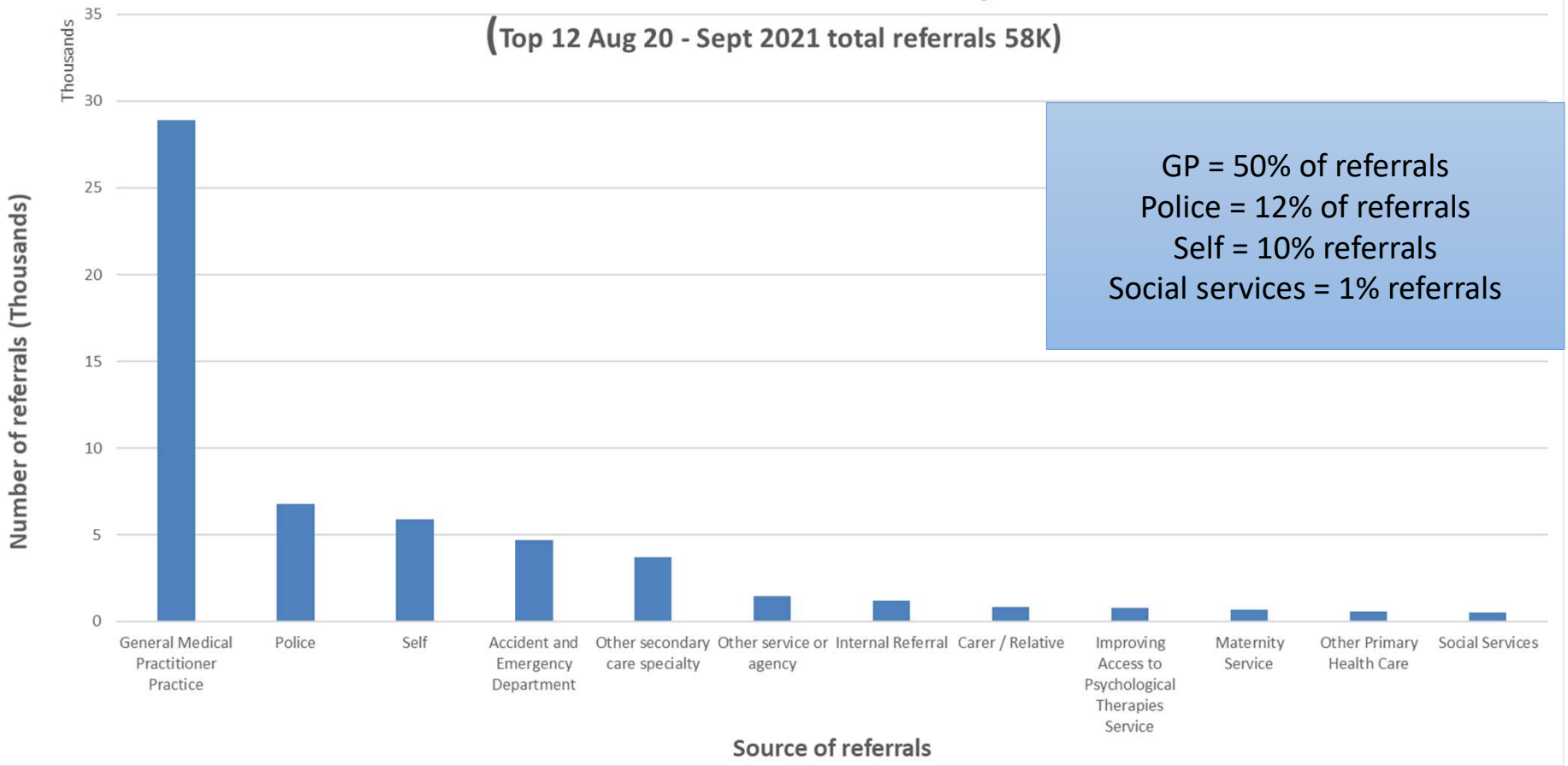
Multi Vote	Idea	Rank Order						
		UU	SB	JP	HS	JL	MP	Total
	Black, Asian and minority ethnic groups (including people from Eastern Europe, Gypsy, Roma and traveller communities)	1	1	1	4	2	1	10
	Forced migrants, refugees and asylum seekers	2	2	2	1	1	6	14
	People with autism spectrum disorder	4	6	4	3	3	2	22
	Men from Black, Asian and minority ethnic groups	3	4	6	2	5	5	25
	Offenders and prison population	6	3	3	6	4	4	26
	LGBTQ+	5	5	5	5	5	3	28

Number of referrals to NSFT by source

(Top 12 Aug 20 - Sept 2021 total referrals 58K)



GP = 50% of referrals
Police = 12% of referrals
Self = 10% referrals
Social services = 1% referrals

NB: 1 individual could have more than 1 referral

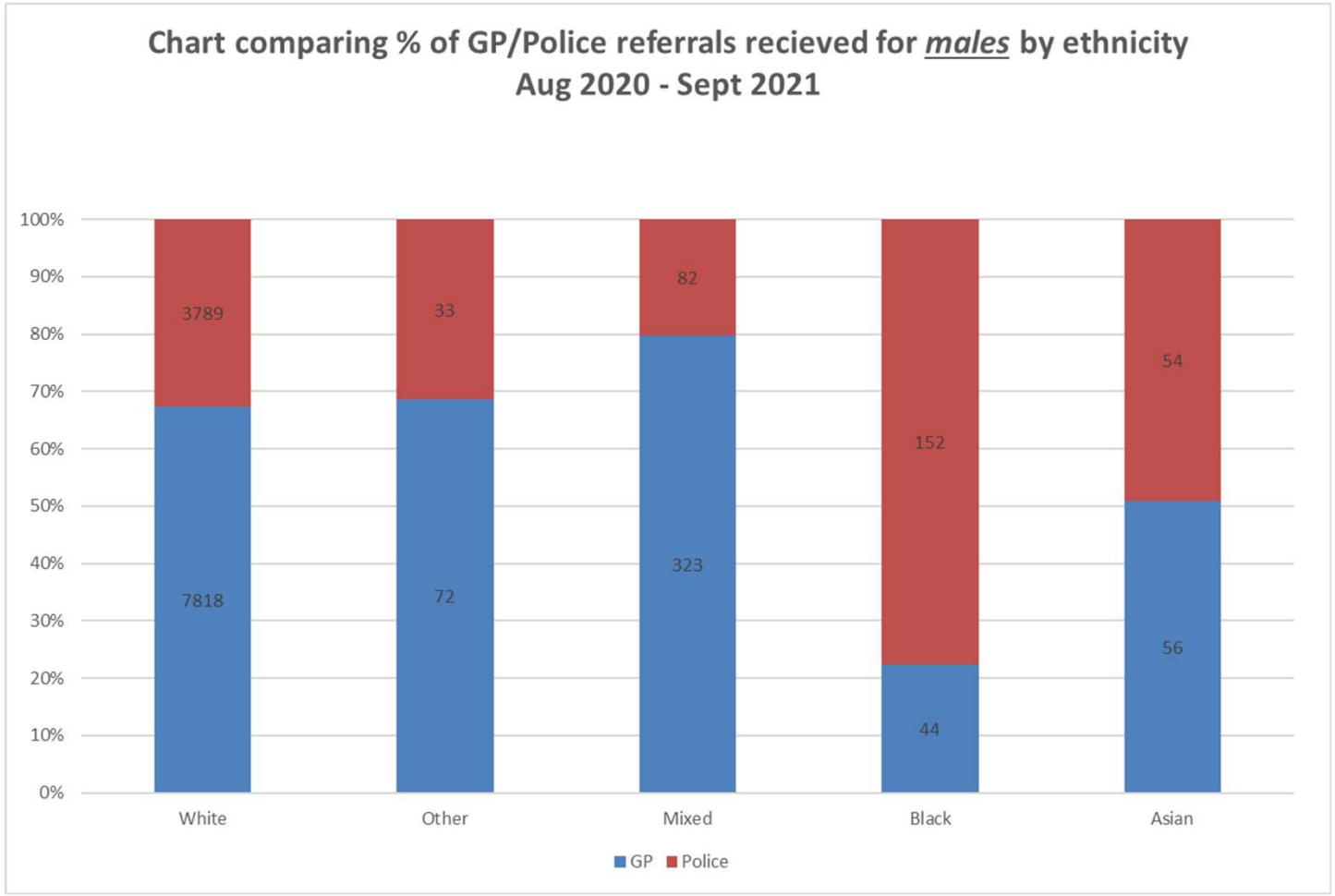
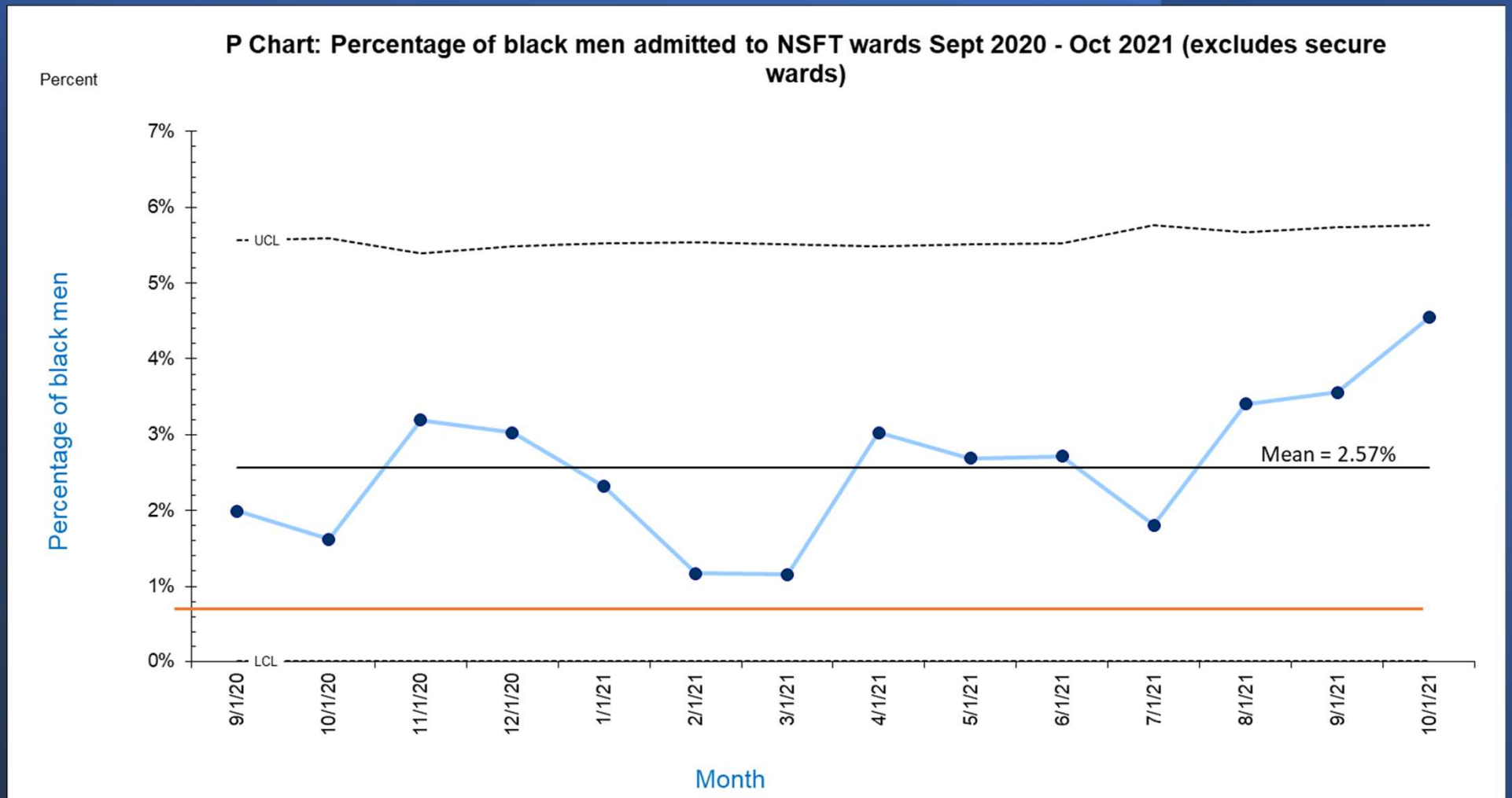


Chart comparing % of GP/Police referrals recieved for males by ethnicity
Aug 2020 - Sept 2021
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3789
7818
33
72
82
323
152
44
54
56
White
Other
Mixed
Black
Asian
GP
Police


P Chart: Percentage of black men admitted to NSFT wards Sept 2020 - Oct 2021 (excludes secure wards)
Percent
Percentage of black men
7%
6%
5%
4%
3%
2%
1%
0%
UCL
LCL
Mean = 2.57%
9/1/20
10/1/20
11/1/20
12/1/20
1/1/21
2/1/21
3/1/21
4/1/21
5/1/21
6/1/21
7/1/21
8/1/21
9/1/21
10/1/21
Month

NSFT 2020 Data: Prone Restraint vs Non-Prone Restraint by Ethnicity

All ethnic minorities were **30% less likely** to have had prone restraint compared to White British people. The same trend was seen for rapid tranquilisation but not seclusion.

But

Although numbers are small, **Black African** people were overall 7 times more likely to have had a prone restraint compared to White British. This finding was consistent for both men and women.

No other ethnicities had significant increases in likelihood of having a prone restraint or seclusion.

Overarching project team

Black men
Sub project group

Population 2
Sub project group

Population 3
Sub project group

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Three-part Data Review – explore needs and assets

1. Review available data on the population to identify overall patterns that impact the chosen population
   - Referral patterns for black men, trends in use of inpatient beds
   - Data requests ongoing

2. Engagement with care teams and professionals providing care or supporting the population to understand their perspective on the black men's greatest needs and assets
   - Men's Mental Wellbeing Lead, Chaplain with links to community groups
   - BME Network at NSFT and other organisations

Three-part Data Review continued

Service user and citizen interviews/engagement to understand their experience and perspective; to understand what is important to them, the real-world challenges they face in managing their health and living situations, and what might help.

- Survey – codesigned with people with lived experience
- Focus Groups
- Individual interviews

Population segment	Is data available?	Can we get our arms around the population?	Is there urgency?	Is there any work already happening?	Do we have existing relationships with key stakeholders?	Is there a governance forum that brings stakeholders together?
Forced migrants, refugees and asylum seekers	Hoping for data from outreach team and clinic		Lots of new migrants moving in and they have nothing	Listening project (ICS). Experiences during COVID-19	Contacts who will help link us to community groups. Refugee nurses	
People with ASD and ADHD	Informatics		Long waits			
LGBTQ+			Yes	MH research priorities for LGBTQ+ service users	Norfolk LGBT+ Project. Suffolk Gender Identity Hub	
Gypsy, Roma and Traveller communities			Yes	Listening project (ICS)		

What are the next steps?

Choosing the second (by Christmas) and **third populations**.

Confirm members of Sub-project group for black men

Explore needs and assets as above

Continue to build on communications internal/external

Questions

NHS
Pennine Care
NHS Foundation Trust

Our approach: AMHE

By Amraze Khan
Head of Equality, Diversity & Inclusion

Maximising potential

NHS
Pennine Care
NHS Foundation Trust

Our key facts

Mental health and learning disability services

Number of sites we operate out of **100**

Serving a population of **1.3m** in Greater Manchester

Providing **132** mental health and learning disability services in total

12 Key commissioners in the areas we serve

Number of beds **529**

Number of staff **3,600**

Providing care in **5** boroughs in Greater Manchester

Pennine Care in numbers

Project board

Pennine Care
NHS Foundation Trust

- Developed with sponsorship from our Director of Nursing, Quality and Deputy CEO. Membership includes Director of Workforce, NEDs, medical director and Head of Patient Involvement and Head of EDI
- Continuous paid service user involvement

Progress to date

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NHS Foundation Trust

- 2x Project Board meetings
- Agreed 5 populations
- Engagement plan developed
- Service user involvement finalisation

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Engagement

- Staff engagement
- Service user engagement
- Community engagement
- Stakeholder engagement

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Next steps

- Further development of engagement
- Service user involvement agreed and developed

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Thank you

Maximising potential

www.penninecare.nhs.uk

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Panel discussion

Laura-Louise Arundell
National Collaborating Centre for Mental Health

Mark Farmer
National Collaborating Centre for Mental Health

Raj Mohan
South London and Maudsley NHS Foundation Trust

Lade Smith
National Collaborating Centre for Mental Health

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Break

Now playing: A playlist curated by teams taking part in our Enjoying Work quality improvement collaborative.

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Co-production session

Mark Farmer- Carer representative on the Equality Taskforce.

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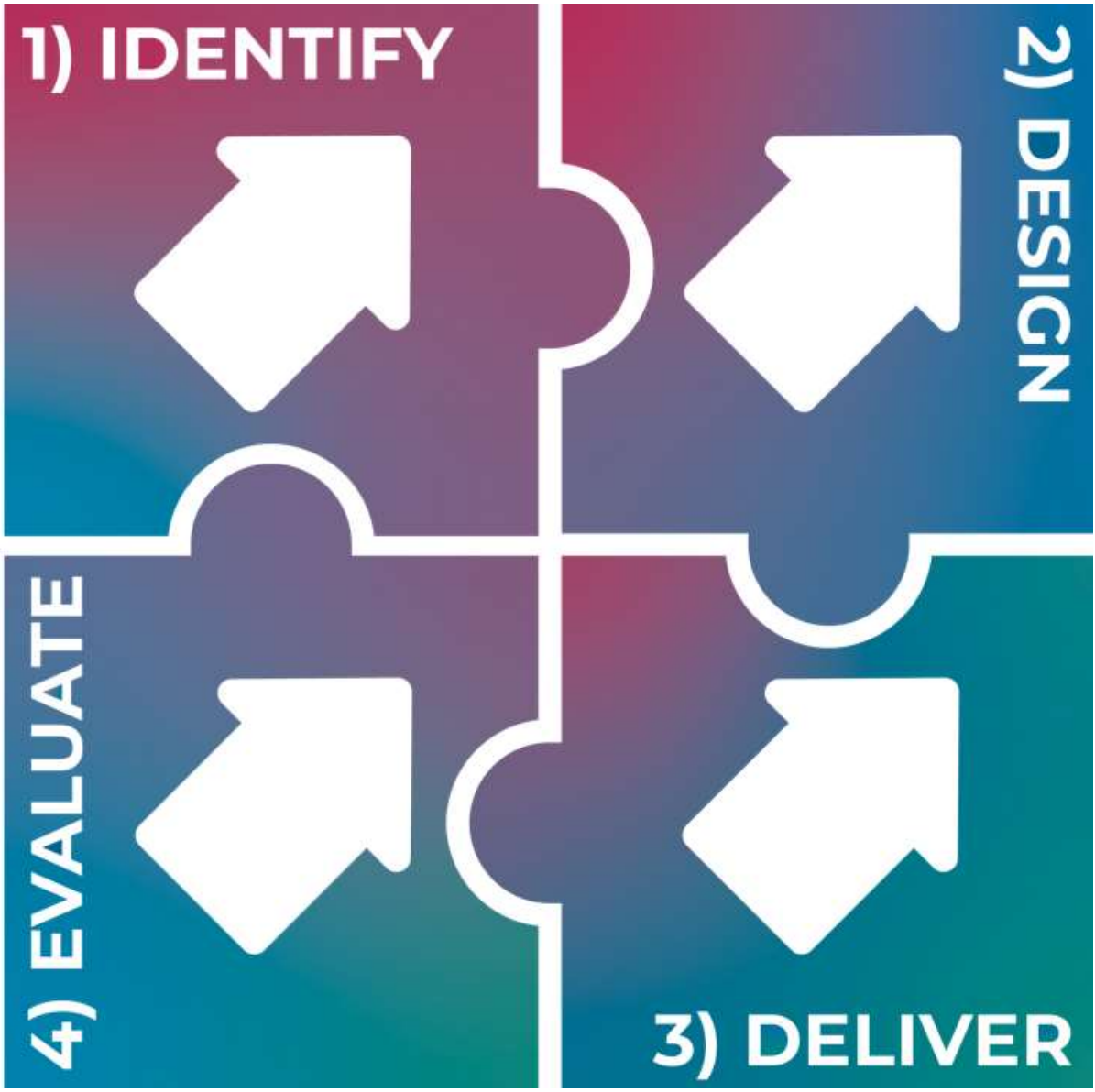

What is co production?

What is coproduction?

- It refers to a way of working where service providers and users, work together to reach a collective outcome. The approach is value-driven and built on the principle that those who use are best placed to help design it.
- It is at the top of the ladder of participation and is not an easy thing to do.
- It is not realistic to co-produce everything and there are limited examples of really good co production.

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Why do it?

Why do co-production?

- Research shows that a service that has been commissioned based on the principles of co-production is more likely to be cost-effective, responsive and have high satisfaction and health outcome rates from people using it.

- It enables you to work with people from diverse communities in partnership with them to create services which meet their individual needs and helps to address, health inequalities- An ICS priority for **all areas.**

- New NICE guidance on shared decision making recommends it as best practice. It also recommends the creation of a patient director with lived experience.

Making it happen in practice

We will work in groups to consider how you can make this happen in practice:

Three tasks-

1. Talk about what your experience of co-design and co-production is
2. What you have found some of the barriers to engagement and involvement at this higher level of the ladder to be
3. Discuss, if you were able to, how you overcome those barriers

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Tips for successful co-production

Tips for successful for co-production

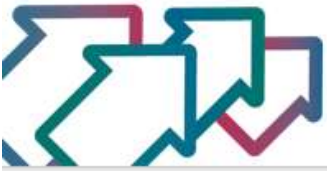
- Be clear as an organisation on what your vision of co-design and co-production- produce that vision with your patients and carers
- Create paid lived experience roles- helps ensure that there is a diverse range of views around the table
- Senior level ownership through an executive level patient director
- A training programme to help make co-production happen well
- Have a wide range of community members around the AMHE project board table, be clear about roles, making them equal partners- you have the power to make it happen

In conclusion

Time to reflect on the possible impact of co-production

Bristol North Somerset & South Gloucestershire CCG

- "We have a dedicated commissioning post, to ensure that co-production is embedded in all areas of the mental health commissioning cycle including transformation. This involvement supports the programme of quality assurance for all mental health contracts with a user-led independent mental health network which has been involved in several procurement processes and the monitoring of mental health providers."



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Next steps

Tom Ayers

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