**EMHIP Working Group One**

**Monday 30th 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 |
| JT | Jayne Thorpe | NHS South West London CCG |
| RM | Ruth McKinney | Wandsworth Community Empowerment Network |
| BDP | Bishop Delroy Powell | New Testament Assembly Church |
| NA | Naseem Aboobaker | Mushkil Aasaan |
| SS | Professor Sashi Sashidharan | Consultant to the EMHIP Project |
| MR | Mark Robertson | NHS South West London CCG |
| CB | Charlotte Blayney | Wandsworth Adult Social Care |
| JS | Jennifer Sangalang | NHS South West London CCG |
| LC | Lystra Charles | Hope Atrium, Pastors Network for Family Care |
| GN | Dr. Gautam Narayan | GP & NHS South West London CCG |
| SF | Professor Saeed Farooq | University of Keele |
| KO | Kalu Obuka | NHS South West London CCG |
| MW | Michelle Woodward | NHS South West London CCG |

**Apologies:** Ricky Dalton SWLSTG,

**Glossary:**

EMHIP – Ethnicity & Mental Health Improvement Project

NTA- New Testament Assembly Church

WG – Working Group

CMHT – Community Mental Health Team

PCP – Primary Care Plus

PCN – Primary Care Network

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)  [Working-Group-1.-Core-Principles](http://wcen.co.uk/wp-content/uploads/2021/01/Working-Group-1.-Core-Principles.docx) |
| **Scene Setting** | MG introduces SS (Project Consultant) who will chair these working groups. SS gives some background on the community mental health and wellbeing hubs and the significance and uniqueness of this element project. He identifies 2 challenges up to now: lack of commitment and money from the NHS and the lack of a programme for change. He comments on the dedication and experience of those in this WG. This WG will drive the direction of travel and a lot of working will take place outside this meeting.  MG gives a background to the hub and spoke model and how NTA will be the first pilot site (from April 2021). Whilst NTA will the central node in the hub, it is envisaged that it will develop links with and work alongside the several community, faith and business groups within its catchment area, including local secondary school, youth centre, well-being centre, Barbershop, Restaurant etc,  SS talks to the function of the hubs – as direct access to specialist medical services (access point), as part of a joined-up, bi-directional care pathway, and as a safe space in the community.  JT comments the difficulties involved in setting up a new system, but also the vital need for EMHIP. To progress, we must break the implementation tasks into smaller pieces (patient data, confidentiality etc.)  MR mentions BME patients already in CMHTs and bi-directional pathways. People getting picked up before getting into CMHT. SS responds that the Hubs will add value to and bridge the gaps between communities and CMHTs, PCP and other mental health services. The hubs can also help with complimentary work e.g., spiritual, work with the family etc. Work needs to be done on tying the pathways up.  GN refers to the PCNs and the role they could play – what does it look like as a short, medium and long-term role, the short being Covid-19. Patients would benefit from EMHIP. What would the impact be? He will report back to PCN colleagues and look for a further meeting re. General Practice. Primary Care Board links with Primary Care Programme – would be supportive in a roll-out.  SF is new to the project and says what he has heard so far sounds good, and his concern is the coordination of networking everything together. MG responds that this intervention sits alongside 4 others, as part of a whole system, and indeed management of the coordination and organisation of the different components to make the project work together is a critical task.  MW comments on the scaling up of EMHIP to SW London and there is lots of support for the project. MG comments that it needs to be taken to this SW London – Integrated Care System level and be driven by them.  BDP mentions his 30 years of work in this area with not much change. He hopes this is a defining moment, and the meeting highlights the challenges faced. | Further conversations with Ricky Dalton, CMHT. |
| **Key Tasks** | SS identifies a ‘software problem’ (how do we write the programme – the function) and a ‘hardware problem’ (operational policy, governance, risk etc.) He summarises the need to consult, pull data together, put together an operational policy/ service spec. This will be based on WG conversations and KI report. This WG will work on amending this.  Need to take this work systematically, have individual follow ups and identify gaps. MR responds that it might be useful to have a breakdown of EMHIP in a visual way – PPT slides or a table? GD adds that service specification template tools can be used as a supporting narrative for long-term commissioning funding and can act as a checklist. SS responds that we need to work through EMHIP in manageable chucks and time will be needed for understanding.  LC responds it is exciting and highlights challenges of internal SWLSTG teams not knowing each other and how to get the buy in from everyone needed. Also, about marketing it effectively, and show the importance of EMHIP.    CB comments on the work of the Council adult social care services and their work in outreaching and change. She mentions wellbeing, prevention, information and advocacy as ways they can support. MG responds asking how EMHIP can also support Adult Social Care too as a two-way process.  JS wants to see the link with Primary Care and General Practice and agrees that visual slides will help in understanding. Also sits on the Transforming Primary Care Delivery Group and can bring EMHIP to them.  MG asks for colleagues to feedback to the project on any matters arising, ideas, opportunities for partnership and collaboration and keen to run this work as a dynamic and inclusive project. | SS to put together a draft service specification and share  Follow up with key individuals  Work on a visual model of EMHIP. |
| **Date of the next Meeting** | MG suggests two meetings a month. GD asks the group to reflect on this and get back to her, and the need to align with St. George’s Hospital mental health colleagues. | GD to confirm dates and send round |