NHS North East London

Minutes of the North East London Community Health Collaborative Sub-Committee

Monday 18 September 2023; 1500-1700 meeting via Microsoft Teams

Members:	
Paul Calaminus (Chair)	Chief Executive, North East London NHS Foundation Trust
Ruth Bradley	Director of Nursing, East London NHS Foundation Trust
Richard Fradgley	Director of Integrated Care and Deputy Chief Executive Officer, East London NHS Foundation Trust
Johanna Moss	Chief Strategy and Transformation Officer, NHS North East London
Charlotte Pomery	Chief Participation and Place Officer, NHS North East London
Selina Douglas	Executive Director of Partnerships, North East London NHS Foundation Trust
Mags Shaughnessy	Interim Divisional Director for Children's and Community services, Homerton Healthcare NHS Foundation Trust
Kate Turner	Strategy Programme Manager, Barts Health NHS Trust *Representing Mark Turner, Director of Strategy and Integration, Barts Health NHS Trust*
Attendees:	
Sally Adams	Director for the Community Collaborative Programme, North East London NHS Foundation Trust
Toyin Ajidele	Transformation Programme Lead Community / Community Health Services, NHS North East London
Brid Johnson	Executive Director of Integrated Care London, North East London NHS Foundation Trust
Kath Evans	Director of Nursing (BCYP) at Barts Health & Clinical Lead for the BCYP NEL ICS/ICB
Siobhan Hawthorne	BCYP programme manager, NHS North East London
Christopher John	Interim Programme Delivery Lead-Babies, Children and Young People, NHS North East London
Sarah Khan	TBC
Julia Summers	Head of Finance, NHS North East London
Keely Horton	Governance Officer, NHS North East London
Apologies	
Ann Hepworth	Director of Strategy and Partnerships, Barking, Havering & Redbridge NHS University Trust
Mark Turner	Director of Strategy and Integration, Barts Health NHS Trust
Ben Braithewaite	Medical Director, Community Health Services, East London NHS Foundation Trust

Item	Item title
1.	**Welcome, introductions and apologies:** • Declaration of conflicts of interest The Chair, Paul Calaminus (PC) welcomed those present in the Teams meeting to the September 2023 meeting of the NHS North East London (NEL) Community Health Collaborative Sub-Committee (CHCSC or ‘the Collaborative’).

	Apologies were received as indicated above and the Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the committee. No additional conflicts were declared.
2.	**Sub Committee business:** • Minutes of the last meeting • Action Log • Matters Arising The Collaborative received minutes of the meeting that had taken place on Monday 17 July 2023 and agreed them as a true reflection of the meeting. The Collaborative recognised that no actions arising from previous meetings remained open.
3.	**Babies, Children & Young People's strategic update** Kath Evans (KE) verbally briefed members on the strategic work for babies, children and young people. Key points noted were: • Lauren Jones has undertaken work on data visibility which is being now being provided on a monthly basis and is proving to be most helpful. Lauren is working directly with providers to certify an accurate view on the challenges and waiting times are provided across NEL. • Leadership provided by both Sarah Wilson and Melody Williams. Colleagues are being brought together to discuss the challenges with waiting times, recognising that there are opportunities to improve pathways and learn from each other and potential to provide mutual aid. • Chris is helping to support coordinate an event planned for the 15 November 2023. Facilitation is being provided by Carys Eastern. This event will bring both clinicians and managers together. • Joanne Beckmann who is a Community Paediatrician (ELFT) and Royal College of Paediatrician and Child Health Fellow and Ambassador is working on clinical leadership. Bringing clinicians together to work towards the national programme. Data packs are being shared with Community Paediatricians and Clinical Leads across NEL. • Deep Dive in SALT and audiology. Community Paediatricians have expressed challenges with Community ASD and ADHD pathways and transitioning into adult services is a challenge. • Ongoing opportunity to influence future business cases by continuing to work cohesively across NEL. Collaborative members thanked the team for the update and their work and discussed the following points: • Collaborative discussions have been very helpful. Putting the child at the centre to determine what needs to be done differently. Next step will be looking at Place as variations across Place and some solutions sit with Place. • Recognise the difficult financial circumstances for the system. Pulling clinicians together for the event on the 15 November will be very helpful. • Prioritisation framework for integrated care system. CYP is one of the four priorities for the integrated system. How do we major children in terms of next year's planning process as the Community Collaborative will be driving the planning process for CHS. • How do we formalise the BCYP work as in improvement network under the collaborative and what we need to do to make sure the young persons voice is

	heard. Planning round for this year and coordinating across NEL, and looking at what is happening in each Places and consolidate and think about where inequities are across NEL. • Infrastructure issues, such as integrated data records across not only health and care but also education. Data digitalisation could be an area where there is a combined effort. • Development of key worker role for most vulnerable young people and potential impact this will have. • Improvement Network (Clinical Advisory Group) will be Clinicians coming together in a community space. A scoping meeting will be taking place on 15 November to take forward the Improvement Network. • Planning piece – 3 October – The next phase of planning will take place on 3 October and will discuss and sign off the planning process and priorities. This will dovetail with system overview and planning work. • Deep dive into community services at the end of October. **ACTION:** Johanna Moss will circulate planning timeframes. **ACTION**: Sally and Selina to collate list of Clinical Leadership names across NEL.
4.	**Outcomes and action plan following the August 2023 Away Day** • **Improvement Networks** • **Terms of Reference & Joint Committee Arrangements** Sally Adams (SA) and Selina Douglas (SD) provided feedback following the strategic session on 25 August 2023 and shared the action plan. Key highlights included: • The purpose of the session was to consider the strategic development of Community Collaborative, taking into consideration what had been achieved historically and the potential future direction. • Attendees felt significant progress had been made and agreed that there was more that could be done to clarify the future direction with Effort Vs Gain. • Working collaboratively to help strengthen the position of Community Services in the health sector. • The collaborative has focused on niche areas that have separate funding streams and services with waiting lists issues. Although these are important and topical, this does not necessarily mean that these are the right areas to prioritises to deliver the biggest impact. • Potential future scope was explored and ways to support community services that could benefit from additional support to update their service specifications. • Outcomes of the session will be discussed and considered with the Community Collaborative Delivery Group and subcommittee. • A planning paper will be developed for the next session and will outline the role of collaborative and a community diagnostic exercise will take place. • Improvement networks will be developed with BCYP will be the first and discussion and agreement for further ones. • Further work needs to be done on patient leadership to develop a stronger user voice. • Discussion around considering to move from current arrangements of a collaborative, to a more formal committee in common and joint committee. The Community Collaborative will need to be on par with other collaboratives. • A new Director for the Collaborative will be appointed October 2023. • The next session is on 3 October to review progress on actions and will bring back findings to the November Community Collaborative.

	Collaborative members thanked the team for the update and their work and discussed the following points: • How does the community collaborative want to use the opportunity to come together and whether this might look similar to other collaboratives? What is the role and shape of this collaborative. • How do we learn lessons from everywhere and how do we make sure we don't end up in a silo with duplication of work across collaboratives and interacting work programmes with other collaboratives. • Interface between collaboratives and Place and strengthening paths, recognising the diversity between Places and community services. It is important to not loose focus with the person at the centre. • Importance of working groups that sit under the delivery group. Working groups are formed of clinicians, patients, careers and link with partners. It is important the clinical voice and service user voice is heard. **ACTION**: ALL to read the paper on Joint Committee and consider the possibility of moving towards this new arrangement. This will be discussed further at a future meeting.
5.	**Community Collaborative Finance Update** Julia Summers (JS) briefed the Collaborative on the contents of the circulated paper, highlighting that: • Community Health Services (CHS) accounted for approximately 11% of ICB planned spend. At month 5 this equates to an ICB budget of approximately £465m out of a total budget of circa £4.5bn. • All partners in the ICS (providers and the ICB) are reporting significant financial pressures, with a large year-to-date deficit reported for the first few months of the financial year. The drivers of the deficit is slippage on the delivery of cost improvement plans, inflation, pay pressures, industrial action and existing run rate pressures. • The pressures seen to date mean that a formal system finance recovery plan (FRP) has been developed and shared with NHSE. • Work is ongoing to identify further opportunities to bring the system to a break-even position by year-end. Work is ongoing to identify further opportunities to bring the system to a break-even position by year-end. • Delivery of the FRP will be dependent on improved delivery of efficiency savings, enhanced financial governance, tighter grip and control of expenditure and non-recurrent measures. This will apply to all spend across the system. • At Month 5 (August 2023), the ICB Community Health Service reported a year-to-date over spend of £640k and a full year forecast outturn of £1,523kk. Whilst the NHS providers and hospices are predominantly on plan, there are overspends in other areas of community services. • The main variance to plan is against the hospital discharge pathway, rehab and associated equipment costs in the community setting. This is reported predominantly in Barking and Dagenham, Havering and Redbridge places. The costs in the inner London boroughs are being offset in 23/24 by non-recurrent section 256 funding. • Aging Well schemes are now all in place and are a continuation of year 1 and 2. • Long Covid plans have been reviewed and values assigned to providers to continue to deliver the long covid service. • Key challenges continue to be waiting lists, recruitment and mobilisation of plans and financial pressures across the system. Members thanked JS for the presentation and discussed the following points:

	• Month 5 position and variance of community health contracts, there is quite a substantial forecast variance towards month end. How this is being managed systematically as a system. • How do we get to a point of understanding where money is not being spent and consequences and managing this? Trying to find a way to stream, manage the flow and maintain safety with an increasing waiting list. This will all link up with workforce as workforce will become more under pressure. Would be helpful to have a separate conversation on what finance needs to be reported. • It would be helpful to disaggregate the acute health into what is associated with community physical health and mental health. The mental health includes acute in the 11%. The pie chart would be helpful to view the acute health disaggregated from the other elements. • Discussion around Discharge fund work and BCF is managed via a different budget and not necessarily community services figures. It would be helpful to explore how the money is linked. **ACTION**: Selina, Malcolm, Andrew and Julia to meet and discuss finance data to be reported. The provider position is not included in current finance reports and is more of an ICB position. Would be helpful to explore and discuss what finance reports should include to reflect finance data across community.
6.	**Community Health Services Diagnostic** Sally Adams (SA) briefed members on the circulated paper, highlighting that: • The specification lays out requirements for a supplier to provide Community Services diagnostic for the NEL Integrated Care System. • The work will help identify the current service provision, providing opportunities to positively transform services to better meet the needs of local people. • Building upon the previously undertaken high-level service mapping to provide actionable insights to both the NEL Community Collaborative and place-based teams to deliver priorities for 23/24 and 24/25. • The mapping exercise has identified variations in how some services are commissioned and delivered and how some residents are able to access services in certain boroughs that neighbours across borough lines may not be able to. • The population of NEL is set to grow substantially over the coming years. Need and demand will continue to grow and will increase demand pressures on services. • Services that are fragile would benefit from either being provided jointly or working in a more networked way at scale across NEL. • SD updated that discussions had taken place whether it would best to consider individual lots. Upon reflection and further conversations, it will be recommended to the Board that the business case to NHSE should not be individual lots. Therefore, subject to advice from procurement, the recommendation to the Board will be to procure as one product. Member discussed the following points: • Recommendation of including a phase between 0 and phase 1a around development of technical operational definitions to the activity wish to count. • Discussion around list under 1a and whether this data is already available. • Information is available from NHS benchmarking, but is not consistent. Triangulating information is not always accurate because of the various definitions. • Suggestion to include a quality metrics as this is important when establishing equality of access.
7.	**Update from Delivery Group**

	Brid Johnson (BJ) verbally updated members, the Committee noted that: • Focus around waiting lists and data review to determine an accurate picture. Different descriptions are used which causes disparities. • Emerging insulin pump will be explored further. Intention was to reduce nursing input to patient as would be managed by patient. However, there is an increase in nursing cost, linked to equipment usage and monitoring. • Future planning and being ready for money is available. Looking at growth funding and health inequalities funding. • Progress is slow on virtual ward and is being monitored elsewhere and now receive updates. • Capacity and demand work continue to be discussed with ongoing work.
8.	**Any Other Business** No further business was discussed.

Date of next meeting: Monday 20 November 2023, 1500-1700

North East London Health & Care Partnership

Agreed minutes of the Mental Health, Learning Disabilities and Autism Collaborative Sub-Committee

13 September 2023, 9.30am – 11.30am - Microsoft Teams

Members:	
Eileen Taylor (ET), Chair	Joint Chair, East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT)
Zina Etheridge (ZE)	Chief Executive Officer, NHS North East London
Johanna Moss (JM)	Chief Strategy and Transformation Officer, NHS North East London
Steve Collins (SC)	Director of Finance, NHS North East London (Representing Henry Black)
Prof Dame Donna Kinnair (DK)	Non-Executive Director, ELFT
Lorraine Sunduza (LS)	Interim Chief Executive Officer, ELFT
Paul Calaminus (PC)	Chief Executive Officer, NELFT
Selina Douglas (SDo)	Executive Director of Partnerships, NELFT
Darren McAughtrie (DM)	Director, Adult Care & Quality Standards, LB of Walthamstow
Dr Mohit Venkataram (MV)	Lead Director for New Models of Care, ELFT
Attendees:	
Nawshin Ali (NA)	Lived Experience Leader
Aurora Todisco (AT)	Lived Experience Leader
Marcella Cooper (MC)	Lived Experience Leader
Christopher Baker (CB)	Lived Experience Leader
Robert Hunter (RH)	Collaborative People and Participation Lead, ELFT - observer
David Bridle (DB)	Chief Medical Officer, ELFT
Wellington Makala (WM)	Chief Nursing Officer, NELFT
Dr Sarah Dracass (SDr)	Medical Director, in-patient mental health (ELFT & NELFT) item 4.3
Dr Imrana Siddiqui (IS)	GP representative
Carys Esseen (CE)	Deputy Director of Integrated Care, ELFT
Jamie Stafford (JS)	Program Director for mental health – urgent & emergency care, NELFT - item 4.1
Malcolm Young (MY)	Executive Director of Finance, NELFT
Sue Boon (SB)	Director of Delivery, Waltham Forest, NELFT
Sarah Khan (SK)	Chief of Staff to Chair of ELFT and NELFT
Anna McDonald (AMcD)	Senior Governance Manager, NHS North East London (Minutes)
Keely Horton (KH)	Governance Officer, NHS North East London - Observer
Apologies:	
Henry Black (HB)	Chief Finance and Performance Officer, NHS North East London
Sultan Taylor (ST)	Non-Executive Director, NELFT
Richard Fradgley (RF)	Director of Integrated Care & Deputy CEO, ELFT

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting including Lorraine Sunduza in her new role as Interim Chief Executive Officer of East London NHS Foundation Trust (ELFT); Rob Hunter, in his new role as Collaborative People Participation Lead attending as an observer; Dr

	Sarah Dracass, Medical Director for inpatient mental health services (NELFT and ELFT) attending for agenda item 4.3 and Jamie Stafford, Programme Director for mental health in urgent &emergency care attending for agenda item 4.1. Apologies were noted. The Chair advised that due to a national exercise in regard to the mental health investment standard spend, a finance report had not been included as part of this agenda for this particular meeting but it would be back on the agenda for the next meeting. As part of the introduction, the Chair commented that the meeting agenda was mental health focussed and emphasised the need to ensure that learning disabilities and autism is on the agenda for discussion at every meeting. **ACTION: RF/SDo**
1.1	**Declaration of conflicts of interest**
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the sub-committee. The register of interests was noted and no additional conflicts were declared.
1.2	**Minutes of the last meeting**
	The minutes of the meeting held on 21 July 2023 were agreed as an accurate record pending two minor amendments needed in sections 2 and 3.
1.3	**Actions log**
	Action Ref 019 - re-visiting the process in place in the past, where a vulnerable adults list was shared with the local police to help share awareness and support an appropriate response • committee members noted the update in regard to this having been raised at the NEL/Met Police meeting on 31 July 2023 and that it will be progressed through the planned monthly meetings. The Chair asked for the action to remain open so progress can be monitored. All other outstanding actions were either on the agenda, forward plan or in progress.
2.0	**Senior Responsible Officer (SRO) report**
	PC presented the report and highlighted the following key points: • CAMHS Collaborative funding opportunity - in addition to the significant opportunities being developed as outlined in the report, there is another opportunity involving crisis and out of hours that is being taken forward in outer north east London. Further information will be provided at the next MHLDA board. • Individual Placement Support – the re-tendering process is being progressed and is a significant part of supporting people's recovery and the move back to employment. • Learning disability & autism - an engagement event has been held on the inner north-east London needs assessment which delivered the insights of the needs assessment through interactive theatre, supported by a theatre company of people with lived experience. Two Listening Events have also been held in ELFT and NELFT which were well attended with people with lived experience, their carers, and clinical and care professional staff. • North east London mental health, learning disability & autism diagnostic - the final report from PA Consulting is expected to be available for the next committee meeting.

	• Appointments – Rob Hunter and Dr Sarah Dracass were congratulated on their new roles as mentioned under section 1.0. As part of the discussion, PC referred to 'Right Care, Right Person' and the work being done with the Metropolitan Police and advised that the revised timescale for the commencement of some of this work has been moved to 31 October 2023. Local planning work is continuing and London-wide sessions with the Police are also continuing. The Mental Health, Learning Disabilities and Autism Collaborative Sub-committee: • Noted the report and welcomed the work being done particularly involving crisis and out of hours services.
3.1	**Deep dive**
	3.1 Mental health in urgent & emergency care SDo presented the report joined by JS. The report provided a summary of current activity and demand for mental health care in emergency departments in north east London. It also included a summary of relevant data, an analysis of what is causing delays, and an overview of work already underway in this area through the Mental Health Crisis Improvement Network in the Mental Health, Learning Disability and Autism Provider Collaborative. The following key points were highlighted: • the number of people attending emergency departments for mental health support has remained stable however individuals who breached the 12hr target increased during 2021 particularly in adults. • Emergency departments are reporting high numbers of people facing delays even after a decision has been made for them to be admitted to hospital. There is variation day-by-day, but within north east London, approximately one third of such delays are associated with people awaiting an admission to a mental health bed with the other two thirds awaiting admission to other settings. • The advised level for mental health wards is 85% and currently across north east London we are at an average of around 95%. In outer north east London which has a smaller number of mental health beds, some bed occupancy rates are above 100%. • An increase in length of stay is being seen along with an increase of the acuity and complexity of patients, and increase in the use of the mental health which are all contributing factors. • In regard to health inequalities – an increased proportion of people previously unknown to community services is been seen in the black and minority ethnic communities which is something we need to address as part of this work. • In addition, we are seeing an increase in activity and demand in our community mental health services and crisis services across north east London. • A summary of the high priority projects that the north east London Mental Health Crisis Improvement Network is working on was given and attention was drawn to the 'driver diagram' included in the paper which the high priority projects are addressing. The network consists of all our key stakeholders and it is clinically led. • Winter planning is well under-way. As part of the discussion, committee members: • Noted that mental health bed pressures is a London-wide issue including pressures on private beds, which is likely to get worse as we move into winter. • Noted that work on the renovation of Moore Ward has commenced and everything possible is being done to ensure the required staffing levels are in place in advance of the ward opening which is anticipated to be in October. • Noted the example provided by NA regarding the difficultly experienced by a family member who had been unable to receive access for his specific disability

	requirements as other patients could not be discharged safely. The Chair asked WM to follow-up with NA outside of the meeting. **ACTION: WM** • Noted that although children and young people are included in the overall numbers, they are not included in any of the actions. • Recognised the importance of being able to understand what needs to be done at each level in regard to flow and access and to understand what the specific issues related to particular Place areas and systems are that may need a more bespoke plan of action that addresses local needs. Learning can be shared in regard to discharge as there is scope to do more work in regard to discharge flow out of mental health wards. SDo confirmed that more detailed discussions will be picked up at the mental health Place meetings. • Noted that discussions are underway with Directors of Adult Social care to develop a specific piece of work looking at housing provision and support across north east London linked to admission avoidance and discharge support. • Acknowledged that this is a whole system issue. The importance of early intervention was emphasised together with the need to support primary care colleagues in order to help slow progression to higher levels of complexity and acuity. • Discussed some of the different schemes across north east London including the Additional Roles Reimbursement scheme (ARRS). IS welcomed thee support roles commenting that even though GPs do everything they can when a patient is in crisis, they still end up in A&E. • Noted the helpful personal experience shared by CB in regard to having worked as a security guard in an A&E department. **Action:** More detail about the additional interventions and schemes to be included in the 'priority projects' table. **SDo.** **ACTION:** PC asked for the 'driver diagram' to be presented at every meeting in order to keep track on outcomes. The 'driver diagram' to be regularly refreshed and presented at each meeting: **SDo.** **Action:** Service users' perspective on this to be added to the forward plan for presenting to the sub-committee - starting with people in crisis. **ACTION:RF/SD** The Mental Health, Learning Disabilities and Autism Collaborative Sub-Committee: • Noted the report.
4.0	**Strategy & planning**
	4.1 Framework for developing the mental health, learning disability and autism collaborative plan for 2024/25 SD presented the paper. The key points were: • The plan will enable the committee to understand what work will be taking place to help us to achieve the collaborative's aim and to deliver against our service user and carer priorities. • Service user and carer priorities will be at the heart of the collaborative plan and we will be working with Lived Experience Leaders to select the elements of the mental health priorities they wish to focus on for 2024/25. • An outcomes framework will be co-produced that will enable us to measure the progress we are making. • Our learning disabilities patient leadership priorities will be ready by November. • Our autism patient leadership priorities may not be ready to influence what need to do for 2024/25. A longer lead-in period is being considered.

	• There are still areas still to be added in regard to our autism plan including access to services, waiting times, carers support. • Discussions with Place-based directors are underway about how we ensure Place priorities form part of our planning process. • The system's planning paper will be cross referenced to ensure both are in line. • A draft collaborative business case process has been developed to support us to take a consistent approach to coproducing proposals across Places, providers and improvement networks. The draft process will be taken to the Mental Health, Learning Disability and Autism Programme Board for sign off in September 2023. Members were asked to note that 2024/25 is expected to be an extremely challenging year financially, with only a small increase in funding for mental health, learning disabilities and autism. System colleagues are working closely together and are exploring ways in which resources can be shared to enable us to develop a sustainable Collaborative Plan. As part of the discussion, committee members: • Noted that if there are any changes to the system planning process, the collaborative planning framework development process will be updated accordingly. • Were assured that recommendations from the PA Consulting work will be used to look at where the inequalities are to ensure that the approach will not result in additional inequalities in regard to autism and we will be looking at how we address the gaps in the autism pathway. The Chair asked for the gaps to be shared at the next meeting. **ACTION: SDo** • Noted that for children and young people (C&YP), neuro-diversity and autism in particular is a key focus and the NCEL Collaborative has made funding available for this a priority. The work in the C&YP Mental Health Improvement Network is focussing on autistic children. The Mental Health, Learning Disabilities and Autism Collaborative Sub-Committee: • Approved the Collaborative Planning framework • Noted the draft North East London Mental Health, Learning Disability and Autism Collaborative business case approval process. **4.2 Multi-disciplinary interventions including prescribing and talking therapies for people with common mental health problems** SDo presented the report which addressed a query raised at a previous meeting of the sub-committee regarding the availability of talking therapies and prescribing interventions for people with common mental health conditions in north east London. The following key points were highlighted: • Primary care talking therapies services in north east London see over 52,000 people a year, over 50% of whom report recovery at the end of completed treatment which is in line with national expectations. • Our talking therapy services offer a wide range of therapies including both cognitive and relational therapies and many services are also linked to wellbeing services and offer employment. • Anti-depressant use in north east London has increased over the last five years, however people tend to be on lower doses compared to the national and London average. • We need to ensure we get the right balance to meet changing patient need and ensure we tackle inequalities and reach under-served elements of our population. • Ideally patients should receive an integrated offer of holistic care that spans talking therapies, medication, wellbeing intervention wider determinants like employment.

	• More work is needed to disseminate good practice and standardise the offer across north east London. This is challenging because of the large numbers of patients involved but this also presents us with an opportunity to make a large-scale difference to patients. As part of the discussion, committee members: • Noted the valuable in-sights shared by the Lived Experience leads particularly the importance of providing symbols for people with learning disabilities and autism (LD&A) and the difficulties experienced when having to explain the need for time off work to attend Talking Therapy services to employers. Further information on access and retention and the progress being made in regard to supporting people who do not speak English to be fed-back at the next meeting. **Action: SDo** • Agreed the importance of leading by example in offering employment to people with LD&A. • Noted that the Improvement Network is looking at further opportunities to contact all communities and agreed the need to have equity of access and take-up across each of our boroughs. • Noted that differences in inequalities are linked to recovery rates and drop-out rates and that mental health pharmacists are involved at looking at anti-depressant prescribing. Mental health distress related to poverty was also flagged. The Chair drew the discussion to a close and reminded everyone that due to time constraints and other factors, the committee can only consider common themes during the meeting. Anything related to individual cases needs to be picked up outside of the meeting. The Mental Health, Learning Disabilities and Autism Collaborative Sub-Committee: • Noted the report. **4.3 Commissioning Framework – Mental Health, Learning Disability and Autism Inpatient Services** WM presented the report. The following key points were highlighted: • A number of key themes came out of the national engagement exercise undertaken by NHS England with lived experience colleagues, carers and clinicians. The key themes as outlined in the report were noted. • The ICB is required to develop and submit an improvement plan to NHS England and agreement was being sought for the sub-committee to oversee the work. • Both NELFT and ELFT have established and proactive systems of quality control, assurance and improvement overseen by their respective boards. • A substantive amount of work is already underway and is being achieved collaboratively as a system and members were advised that the paper was being presented to formalise the plans. As part of the discussion, the committee: • Recognised the importance of having a learning disabilities perspective on this and welcomed the offer from MC to be part of the work. WM to liaise with MC outside of the meeting. **ACTION: WM.** • Noted the importance of building on our quality improvement work in the inpatient services across north east London and sharing the learning between ELFT and NELFT. • Noted the importance of co-producing quality improvement projects with staff, service users and carers. The Mental Health, Learning Disabilities and Autism Collaborative Sub-Committee:

	• Noted the new Commissioning Framework and the requirements summarised for ICBs over the next 3 years. • Approved the proposal that the requirement on ICBs to prepare and publish an inpatient improvement plan is overseen by this committee and programme • Considered specific issues or opportunities the committee wishes to see addressed in the plan.
5.0	**Governance** No items.
6.0	**Assurance**
	6.1 Performance report Due to time constraints, the report was noted but not discussed.
7.0	**Forward plan and any other business**
	7.1 Forward plan Committee members noted the forward plan. **7.2 Any other business** NA conveyed thanks to CE on behalf of the Lived Experience Leads for supporting them in helping to put the patient voice at the forefront of the work being done. The Chair added that hearing the experiences of patients provides a real opportunity to inform the work we are doing.
Date of next meeting – 21 November 2023	

North East London Health & Care Partnership

Minutes of the Primary Care Collaborative Sub-Committee

Wednesday 13 September 2023; 13:00 – 15:00; via MS Teams

Members:	
Jagan John (JJ) – Chair	Primary care board rep
Mark Rickets (MR)	Primary care board rep
Johanna Moss (JM)	Chief Strategy and Transformation Officer, NHS North East London
Sarah See (SSe)	Managing Director of Primary Care, NHS North East London
Dr Ben Molyneux (BM)	Associate Medical Director for Primary Care, NHS North East London
Dr Mohammed Naqvi (MN)	General practice rep - clinician
Shilpa Shah (SSh)	CEO NEL Local Pharmaceutical Committee
Attendees:	
Dr Kirsten Brown (KBr)	Place based clinical lead (C&H)
Dr Janakan Crofton (JC)	Place based clinical lead (WF)
Dr Ann Baldwin (AB)	Place based clinical lead (Havering)
Dr Shabana Ali (SA)	Place based clinical lead (Redbridge)
Dr Khyati Bakhai (KBa)	Place based clinical lead (TH)
Dr Kanika Rai (KR)	Place based clinical lead (B&D)
Steve Collins (SC)	Director of Finance, NHS North East London rep for Henry Black
Jignasa Joshi (JiJ)	Chair, NEL Local Optical Committee
Danielle Ellis (DE)	Senior optometrist/Advancement Lead for Local Optical Committees London region
Dr Payam Torabi (PT)	Clinical lead for Population Health and Health Inequalities, NHS NEL
Anna Carratt (AC)	Deputy Director of strategy, planning and performance, NHS NEL
Keeley Chaplin (KC)	Minutes - Governance manager, NHS North East London
Apologies:	
Henry Black (HB)	Chief Finance & Performance Officer
Raliat Onatade (RO)	Chief Pharmacist and Director of Medicines and Pharmacy, NHS North East London
Mark Gilbey-Cross (MGC)	Director of Nursing & Safeguarding, NHS North East London
Dr Sanjoy Kumar (SK)	General practice rep - clinician

Item No.	**Item title**
1.0	**Welcome, introductions and apologies**
	The Chair welcomed all to the meeting and introductions made. Apologies were noted as above.
1.1.	Declaration of conflicts of interest
	The Chair reminded members of their obligation to declare any interest they may have on any business arising at the meeting which might cause them a conflict of interest. No additional conflicts were declared.

	Declarations made by members of the committee are listed on the register of interests. The register is included in the pack of papers and available from the secretary of the committee.
1.2.	Minutes of the meeting held on 12 July 2023
	The minutes of the last meeting held on 12 July 2023 were accepted as an accurate record.
1.3.	Matters arising/action log
	Members noted the action log and agreed to close: ACT014, ACT016, ACT017, ACT019, ACT024. Updates for remaining actions were provided as follows: ACT020 – summary circulated **and action closed** ACT021 – board performance report circulated **and action closed**. ACT023 – SSe advised work to develop a maturity matrix for PCNs has commenced and an outcome from the recent continuity of care workshop is to develop integrated care networks which PCNs are the foundation of. Looking at how to take this forward will come under the Fuller workstream. SSe will work out key principles for integrated care networks. There is also work on the primary care model which includes sustainability and how we may need to co-locate services to support the network and work with McKinseys via the Life Sciences project.
2.0	**Primary care finance report**
	SC provided the Sub-Committee with a summary of the financial position and associated risks, both at a high-level (NHS NEL) but also providing some information at a Place level. SC highlighted the following: • The primary care delegated budget remains stable. However areas such as rent reviews are putting pressure on the delegated budget. • The largest area of increased risk is in prescribing partially attributable to supply issues leading to prescribing of higher cost drugs. • The system is moving into the financial recovery plan so areas are amplified when other factors are considered such as industrial action and inflation rises. Controls are being tightened and areas will be under more scrutiny. • More data will be provided for Dentistry, Optometry and Pharmacy (DOPs) in due course. Discussion points included: • Is there a Cost Improvement Programmes (CIPs) saving requirement from primary care? There is an area of challenge around investment growth including System Development Funding (SDF). A review of the SDF element of the primary care transformation has been undertaken and a plan has been developed to deliver £2m from overall primary care budget. • A deep dive on prescribing could be arranged though there may be a lag in data. All financial data should be provided at place level and if possible at PCN level. • Due to a reporting error a Tower Hamlets practice will have to pay back some Out of Hours monies which will could lead to financial pressure. The primary care team are checking all practices in Tower Hamlets to ensure this has not happened at any other practice and negotiations are ongoing regarding the length of time will be given to pay this back. • There is a high forecast of unutilised ARRS allocations and this data may not be up to date. Information that finance colleagues receive is via the portal so practice colleagues need to ensure they submit their claims monthly. NHSE will only release 60% based on previous months claims therefore clinical leads are asked to communicate to colleagues to submit claims for reimbursement each month.

	• Issues with ARRS include being able to recruit but issues are where to place them as there are limited places with the right equipment and low numbers of workforce and heavy reliance on ARRS and concern with sustaining delivery of care. • GP contract negotiations commence next month for the next year and it is unclear what level of funding will be allocated or benchmarked so PCNs should recruit to maximise their budget. **Action:** Next agenda deep dive on prescribing data **Action:** Clinical leads to feedback message on submitting ARRS claims in a timely manner. The sub-committee noted the financial update report.
3.0	**Primary care risks**
	The risk report provides NEL level risks rated over 12 noting the following: • Lower rated risks are reviewed weekly in the primary care team. • The critical risk on the report is the sustainability of primary care due to a number of reasons such as maintaining staffing levels and cost of living rises. This is also reflected nationally. • The risks are quite broad and it was suggested that these could be broken down further into smaller risks such as resilience or recruitment and retention and mitigations may be more manageable. **Action:** The joint chairs would like to discuss this in more detail with SSe. The sub-committee noted the CSTO Primary Care Directorate Risk Register.
4.0	**Fuller workstream: continuity of care**
	JM and AC thanked colleagues that were able to join a workshop on the Fuller workstream 'Continuity of care' held on 6 September. AC highlighted the following: • The event showcased case-studies and best practice across NEL, to identify and prioritise what success looks like in the development of Integrated Neighbourhood Teams at Place, and what system level support is required to successfully integrate and transform services. • The aim was to identify system enablers which will help local teams develop local plans for integrated neighbourhood teams; to provide our population with resident centred care; and to create a shared understanding of what changes are needed to deliver these and prioritise system level support to develop integrated neighbourhood teams at place. • Many of the identified actions had been highlighted in local meetings with Places, and will include a co-designed outcomes framework, implementation framework (including a self-assessment toolkit) and community of practice to share learning and problem solve together. • Communication could be streamline out to the community. Many discussions focused on digital and workforce and training and care support in roles. • Investment into preventative work and support to patients closer to home was also discussed. • We have a voluntary sector collaborative emerging and need to work closely with them. • Output of the workshop will be mapped to the four workstreams (same day access, continuity of care, people and infrastructure) and agree with our working groups how to prioritise the proposed actions and incorporate them into the overall programme. Members thanked AC for the quick turnaround of the output from the workshop and discussed the following: • There was a lot of learning from a number of wide range of areas.

	• Places had nominated attendees however it was noted that colleagues from the wider primary care community (Optometry and Dentistry) had been absent. AC will ensure wider primary care representation is included in future events. • Cross boundary issues and their complexities were raised at these events and needs further consideration. • The aim is for all to work around the patient and teams would come together to do that. • There needs to be a discussion on shared areas work/interest/ambitions with other collaboratives. Initially a discussion with the community health collaborative would be useful. • This is an opportunity to provide a briefing on Fuller commitments to Optometry and Dentistry colleagues to ensure all of primary care have a shared understanding and knowledge of Fuller. • There is a need to know how to steer this conversation to places for them to deliver and develop within their place based partnerships. Who needs to lead this work and if PCNs can harness the opportunity to start the work involving all areas including DOPs and voluntary sectors. This could be picked up as part of the PCN development. **Action:** To ensure Places have relevant contacts from all of primary care to ensure they are included. AC thanked colleagues for their feedback and noted there is further work to be done to ensure clarity when communicating down to places to include partners on the framework and aims and would like to continue to receive ongoing feedback from the collaborative. Learning from the Big Conversation will support this with examples of what good looks like and incorporate it into how best to form services for our patients.
5.0	**Joint report from the managing director of primary care and (associate) medical director for primary healthcare**
	BM provided key highlights from his report including: • Progress is being made on the access recovery plan including access to patients records. • All 60 of practices that are on analogue systems are being supported to move to cloud-based telephony by March 2024. • Same day access contract extension from October onwards, PCNs will be responsible for this. • There has been a lot of work on the NEL Primary/Secondary Care Interface with work being undertaken to agree NEL level principles and delivery at place/acute provider footprint. SSe noted the following: • There has been a lot of work on the restructure since the last meeting with the majority of the team slotted into posts and interviews for ringfenced staff are commencing. • Babylon have recently announced that they are seeking to sell their UK businesses, including GP at Hand. NHS NWL are confident that there will be no impact on services at this time, but the situation is being closely monitored. • Operose have confirmed that their US owner is seeking to sell Operose following the sale of its other international operations. A task and finish group has been set up regarding this change of control and are currently waiting for more detail. **Action:** A reminder of the access to records offer will be circulated for information to cascade as appropriate to encourage uptake. Members noted: • Progress with the delivery of the Delivery Plan for Recovering Access to Primary Care

	• The update on the ICB's restructure • The Primary Care System Development Funds (SDF) that has been submitted to NHS England and that a briefing report will come to the next Collaborative meeting.
6.0	**Health Equity Academy**
	Dr Payam Torabi (PT) was welcomed to the meeting to present the NEL Health Equity Academy and Event update. PT highlighted the following: • The NEL Population Health and Integration Committee (PHIC) has agreed to three years' funding of £462,000 per year to fund a NEL Health Equity Academy and clinical leadership for population health and health inequalities. • Its aim is to support people and organisations working in health and care to be equipped with the knowledge, skills and confidence to reduce health inequalities for the benefit of local people. • The cost has been met from within the Health Inequalities (HI) funding (7% of total HI funding - 85% of which has been distributed to place based partnerships). • There are two target audiences this year, primary care and the voluntary sector and then it will widen to all in health and social care. • There is still a lot of work to engage with PCN HI leads and are currently seeking a list of all leads to enable this. Members discussed and PT responded to the following questions: • What is being done to deliver this in each place partnership? Stakeholders will be expected to identify their HI leads from places. • Engagement has not yet been planned with dental, optometry and pharmacy colleagues but they will be included once contacts established. • There will be a clear output on fellowships and apprenticeships (linked to anchor roles) in the next year and is expected to strengthen the voluntary sector and will use some funding to enable voluntary and community sector to train other parts of the system. • Surveys and stakeholder feedback will be used to monitor effectiveness. • Health literacy support is considered and looking at a suite of available national support. • Is there learning from West Yorkshire and how they contributed to a shift in quality of care for targeted groups of people? They have relied on feedback from stakeholders and had a successful fellowship programme to help retain staff. The Chair thanked PT for the presentation and members noted the update. The collaborative would welcome a further update as the programme develops.
7.0	**Provider groups**
7.1.	Updates:
7.1.1.	Pharmacy provider group
	SSh gave a brief overview on discussions held at the last meeting in July. Main items of note were: • A vice chair has been appointed and SSh will continue to attend as an observer. • Further discussions had been held on branded medicines shortages of stock and how to work together to ensure patients can get their medication in a safe and timely manner. • Six pharmacies have been approved as Independent Prescribing Pathfinders. It will commence with hypertension and further information will be shared with relevant groups once available. Independent prescribers will be able to have access to the patient's care records such as current medication. It is scheduled to be signed off at the Integrated Medicines Optimisation and Prescribing Committee (IMOC). • Under the trainee pharmacy programme, every pharmacist that completes from 2025/26 will become a qualified prescriber. • Workforce planning will look at pharmacy as a whole including community, secondary care and GP pharmacy.

	• A minor ailment scheme will offer a whole system solution if funding from the inequalities fund is agreed. Members noted the update.
7.1.2.	General practice provider group
	MR provided a brief overview from the last meeting held. Discussion included an update on the general practice recovery plan noting the national requirements and timelines. There was also a focus on technology both hardware and software with new ways of working. Members noted the update.
7.2.	Update on the development of the Dental and Optometry provider groups
	Progress on the development of both the Dental and Optometry provider groups is continuing, with a plan to launch these in the autumn/winter this year. A meeting with SSh is being arranged to consider the learning from the development of the community pharmacy provider group. The sub-committee noted the update and next steps on the development of the dental and optometry provider groups
8.0	**Items for exception report to PHIC**
	Items to feed up to the PHIC are: • Risks and reflecting the need to run more detail and granularity • Reflect discussion on integrated neighbourhood teams • Raise the HI academy and what we flagged here would be helpful. • Primary / secondary interface work to gain traction.
9.0	**Any other business**
9.1.	Safeguarding in primary care Following the high profile trial and outcome of the Lucy Letby case the whole system is reflecting on this and the wider issues emerging about how all healthcare organisations spot and act on warning signs and listen and respond to concerns. There is a need to ensure NEL primary care are included and to ensure issues can be raised across all. The Clinical Advisory Group (CAG) are discussing the case, considering the response and what safeguards are in place. The Quality, Safety and Improvement Committee will be leading on this and a more detailed discussion will be held at a future meeting.
10.0	**Items for information**
10.1.	Meeting forward plan
	Noted.
Date of next meeting – 8 November 2023	