Barking, Havering and Redbridge University Hospitals NHS Trust | Barts Health NHS Trust | Homerton Healthcare NHS Foundation Trust | North East London Integrated Care Board

Minutes of the NEL Acute Provider Collaborative Joint Committee

Wednesday 20 September 2023
held in the King's Fund, Cavendish Square and by MS Teams

Members:	
Sir John Gieve (JG) - Chair	Chair, Homerton Healthcare
Rt Hon Jacqui Smith (JS)	Chair in Common, BHRUT and Barts Health
Shane DeGaris (SDG)	Group Chief Executive, BHRUT and Barts Health
Matthew Trainer (MT)	Deputy Group Chief Executive, BHRUT and Barts Health *via MS Teams*
Lesley Seary (LS)	Joint Non-Executive Director, BHRUT and Barts Health
Louise Ashley (LA)	Chief Executive, Homerton Healthcare *via MS Teams*
Dr Julia Simon (JS)	Director of Strategic Implementation & Partnerships, Homerton Healthcare *via MS Teams*
Dr Michael Gill (MG)	Non-Executive Director, Homerton Healthcare
Zina Etheridge (ZE)	Chief Executive Officer, NHS North East London
Dr Paul Gilluley (PG)	Chief Medical Officer, NHS North East London
Henry Black (HB)	Chief Finance & Performance Officer, NHS North East London
Andrew Hines (AH)	Group Director of Corporate Development, Barts Health
Attendees:	
Lee Basso (LB)	Director of Provider Collaboration
Archna Mathur (AM)	Director of Specialised Services
Anne Marie Keliris (AMK)	Head of Governance, NHS North East London
Keeley Chaplin (KC)	Minutes - Governance Manager, NHS North East London
Helen McKenna (HMK)	Chief of Staff to the Chair in Common, BHRUT and Barts Health
Apologies	
None	

Item No.	Item title	Action
1.0	**Welcome, introductions and apologies**	
	The Chair welcomed all those present and in attendance to the inaugural meeting of the Acute Provider Collaborative Joint Committee and introductions were made. No apologies were received.	
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.	

Item No.	Item title	Action
1.2.	**Minutes of the last meeting**	
	The notes of the Acute Provider Collaborative (APC) Shadow Board held on 29 June 2023 were accepted as an accurate record.	
1.3.	**Matters arising/actions log**	
	There were no outstanding actions from the last meeting of the APC Shadow Board.	
2.0	**Governance**	
2.1.	**Approved Joint Committee terms of reference**	
	Committee members endorsed the terms of reference for the APC Joint Committee which had been approved by respective member Boards in July. They will be reviewed annually.	
2.2.	**APC Executive sub-committee terms of reference**	
	Committee members approved the APC Executive sub-committee terms of reference. They noted that the plan was to review and streamline the membership as it progresses.	
3.0	**Priority programmes**	
3.1.	Specialised Services Delegation	
	AM outlined the rationale, implications and ICB readiness for delegation. NHS England (NHSE) is the accountable commissioner for 154 prescribed specialised services and c65 services have been deemed to be both suitable and ready for greater ICS leadership from April 2024. ICBs are currently undergoing assurance exercises to assess readiness to take on specialised service delegation which if approved, will be taken forward through a formal "Delegation Agreement" requiring ICB Board approval in March 2024. NEL ICB has been assured as a Category 2 system with two conditions around governance and workforce. AM clarified that allocations will move to ICB level from 2024/25 and services not suitable for delegation will remain on a host regional commissioner basis. The budget is estimated at £600m which will be determined through the forthcoming planning round. Highly specialised services will be retained by NHSE. A key risk for all ICBs is the capacity, capability and expertise to deliver localised specialised commissioning. The operating model for the commissioning hub is being worked through and will look at whether regional staff will come together in a 'commissioning hub' or in places. Members expressed concerns that no decision to proceed can be made until further assurances are received including: • Receipt of financial data including current service spend breakdowns and expected budget contributions. • What elements are being delegated and which are maintained nationally? • What capacity will be delegated? • Clarity on which specialised services will be managed by place and which will be kept at system level. • Details setting out opportunities and risks. • Is the process clinically and patient led and what are the risks to splitting up work currently concentrated in centres of excellence?	

Item No.	Item title	Action
	ZE noted there is a London joint committee with NHSE and ICBs and all are flagging risks on funding and resources. The APC structure will manage this through the transformation but the decision has not been delegated to APCs. SDG added that these concerns are being raised at executive level and by boards particularly whilst in financial recovery. HB advised there is limited financial information at present but will emphasise the ACP's concerns of increasing the system's financial risk. HB will suggest a form of risk share arrangement to be managed across London. The Joint Committee noted the report and requested that it is kept informed of financial data and risks, when this is made available, and that further updates will be provided to the November APC executive committee, the November ICB Board and the next APC Joint Committee scheduled in December 2023.	HB
4.0	**System Operational Planning**	
	ZE outlined the pack setting out a process for 2023/24 which is a staging post towards the new ways of working that will ultimately increase integration, collaboration and trust across the system and noted the following: • It will align the planning process with our Financial Recovery Plan (FRP) and medium term financial strategy work. • It aims to understand and mitigate risk as well as developing a system approach to prioritisation. • Emerging key themes include starting the planning cycle early and providing a clear process and timeline. • A series of deep dives are being planned during the Autumn covering the 10 system priorities which aims to understand the connectivity between them and identify risks. • A prioritisation framework is being developed to look at how best to prioritise resources. Members discussed the issues raised and key points included: • There should be a link with social care and an alignment of JSNAs will help to get public health and local authorities connected into the whole system with a focus on prevention. • Members agreed the sense of direction but were concerned that there is a high number of meetings that senior management would be expected to attend when they are already working at full capacity. As well as the uncertainty of financial recovery. • Contingencies should be factored in if the planning goes off track. ZE recognised the concerns that members have about attempting to set long term plans and engaging across the system at a time of extreme operational and national pressure. An operational plan for the system must be developed to demonstrate how NEL will deliver the performance trajectory that NHSE will set. A role of the ICB is to provide support and take some pressure off and will look at making this process a lighter touch for colleagues. There are some must do priorities but will look at what can be flexed to reduce this pressure. The Joint Committee noted the report.	

Item No.	Item title	Action
5.0	**System Development**	
5.1.	Leadership Development	
	ZE summarised progress on leadership development and the procurement of the Learning Partner. The procurement process has been thorough and is now complete. She said a small group was planning to meet with the provider to discuss the framework and requested a member of this joint committee join this group. The Joint Committee noted the verbal update and agreed Ann Hepworth would represent the Joint Committee at the working group.	
5.2.	Development of Partnership Agreement	
	AH advised that, building on the approved terms of reference for the Joint Committee, steps are now being taken to develop a Partnering Agreement between constituent members. The report provided the context to this development and set out the broad areas of focus, noting that we can develop this at our pace and does not require all matters to be concluded at the same time. It is proposed that work will continue with Browne Jacobson and aim to develop this for approval by the end of the financial year. There are benefits in linking the initial stages of this work with the facilitated support of a system learning partner. The intention is to connect these two activities together. Members noted the development of the Partnering Agreement.	
6.0	**Clinical Strategy / Leadership**	
6.1.	Clinical Strategy Board	
	LA provided members with an overview on the development of the Clinical Strategy Board. At APC it would bring together considerations on population health matters, enable clinical and strategy leads to take a NEL view of long-term acute service provision and service transformation initiatives in the round. It would also provide a mechanism for clinical leadership forums to link in with strategic decision making and provide an opportunity to test proposals prior to presentation to the Executive. The Chief Medical Officers have worked with clinicians in NEL to form a variety of clinical board structures and discussed the development of a clinical strategy. At present it will be a live process to develop the strategic priorities through the work of the different clinical boards. Members approved the establishment of an APC Clinical Strategy Board.	
6.2.	Update on NEL Clinical Leadership Model	
	AH provided an update on progress made with developing phases 1 and 2 of the NEL Clinical Leadership model: • Phase 1 – integration of clinical boards with the APC programmes • Phase 2 – development of Medicine and Surgery Clinical Boards supported by Clinical Reference Groups	

Item No.	Item title	Action
	AH noted the following: • The Chief Medical Officers have engaged with clinicians within the APC programme structures and used learning from the Barts Health model and will ensure it integrates with existing programmes. • There is no additional funding to resource this. • The APC Clinical Strategy Board will feed into the APC Executive. • There is management support but there is no administrative support and this needs to be worked through. Members raised the following: • PG will sit on the Clinical Strategy Board as the ICS rep. • This board will be a key opportunity to look at providing access to better quality services. Including communications is vital if there are any change to services proposed. • The Board could have a role in the interface between primary and secondary care. • If local residents can be included it would build a better strategy. • The focus should be on working as a system and ensuring patient engagement is incorporated. Members **noted** the progress in establishing the NEL Clinical Leadership model for the APC and supported the development of the APC Clinical Strategy Board and that it will consider membership and how to link collaboratives into this.	
7.0	**Any other business**	
7.1.	Finance update	
	JG raised concerns that the system financial forecast is worsening. HB informed members that the position started to generate regional interest. A draft Financial Recovery Plan (FRP) had been submitted at month 3. The short term aim of the FRP is to: • stabilise the run rate in months 3-6, which was accepted by NHSE • return to the operating plan run rate from month 6 onwards to a revised shortfall forecast of £55m. There is already some non-recurrent savings in the £55m and it will need to be clarified if balance sheets will stretch further. A deep dive on provider CIPs has been organised and a formal meeting with the Chief Financial Officer, NHS Executive is being arranged. The FRP does not include costs from Industrial Action. The trend has slowed and is moving in the right direction and we are on track to deliver months 4 and 5 but from month 6 it becomes more challenging. The Chair thanked HB for his verbal update which was noted.	
8.0	**Items for information only**	
8.1.	Diagnostic Improvement update	
	Members noted the briefing on diagnostic recovery and transformation which summarises the key priorities and actions for the diagnostic recovery across North East London which include implementing Community Diagnostic Centres, developing clinical diagnostic networks, increasing GP direct access diagnostics, and improving operational excellence.	

Item No.	Item title	Action
8.2.	Q2 Programme update	
	The Joint Committee noted the highlight reports which outlines progress against delivery. These are received and reviewed by the APC PMO and reported to the APC Executive. Highlight reports include delivery against key milestones and risks and issues management, including an overall RAG rating for delivery and overall programme status.	
	Date of Next meeting – 14 December 2023	

Final

North East London

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

Monday 20 November 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
Selina Douglas	Executive Director of Partnerships, North East London NHS Foundation Trust
Bas Sadiq	Deputy Chief Executive, Homerton Healthcare 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:	
Paulin Goffin	System Programme Director for Community Health Services/Community Collaborative, NHS North East London
Brid Johnson	Executive Director of Integrated Care London, North East London NHS Foundation Trust
Andrew Liles	Tri-coordinate team. Observing meeting
Polly Pascoe	Associate Director Quality Development & Patient Safety, NHS North East London
Kevin Curnow	Chief Finance Officer, East London NHS Foundation Trust
Holly Howlett	Associate Director of Operations, Homerton Healthcare NHS Foundation Trust
Julia Summers	Head of Finance, NHS North East London
Keely Horton	Governance Officer, NHS North East London
Apologies	
Richard Fradgley	Director of Integrated Care and Deputy Chief Executive Officer, East London NHS Foundation Trust
Ann Hepworth	Director of Strategy and Partnerships, Barking, Havering & Redbridge NHS University Trust
Mark Turner	Director of Strategy and Integration, Barts Health NHS 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 November 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 18 September 2023 and agreed them as a true reflection of the meeting. The Collaborative recognised that no actions arising from previous meetings remained open. It was noted that the action around finance and data reporting is ongoing and further discussions are taking place
3.	**Patient Safety Incident Response Framework (PSIRF)** Polly Pascoe (PP) talked members through the paper on Patient Safety Incident Response Framework (PSIRF). Highlights included: • The paper highlights the change we can expect to see in patient safety across the Borough and NEL. • The PSIRF will outline the local priorities that organisations will focus on and explain how to respond too. • PSIRF replaces Serious incidents framework (SIF), this will allow providers to prioritise incidents that impact their population and look at improvement and learning more than the investigation its self. • There are some National priorities that will remain, PSIRF only replaces SIF, it does not replace other statuary functions or processes such as safeguarding. • BHRUT, NELFT & Barts are now live with PSIRF plans. • The ICB and ICS will have the ability to have a broad oversight of patient safety incidents and the work being progressed to address them. • The ICB patient safety team will be setting up a System Safety Group. • Learning from Patient Safety Events Service (LFPSE) – will pull in patient safety data and start to report as a system and look at issues which may not be investigated by providers and possibly become an issue and provide advice to providers on how to best adapt their plans. Collaborative members thanked Polly for the update and discussed the following points: • Welcomed future reporting from the LFPSE once available to learn from events and outcomes. • Discussion around patient safety system and patient safety culture and how we might operate as a system and collaborative perspective.
4.	**Planning** Selina Douglas (SD) briefed Members on the circulated proposed framework for developing the Community Health Services Collaboratives plan for 2024/25. Key highlights included:

	• The Collaborative plan development framework sets out how each of the components of the plan will be developed over the next six months to help reach a final draft. • This is a proposed approach to consistent and coordinated planning with Places, providers and wider stakeholders across NEL to impact the outcomes of local people and equal access across communities. • Two workshops have taken place to look at the role of the collaborative and agreed system oversight and planning cycle incorporating the ICB priorities. • 11 December workshop planned to refine the system priorities and taking into consideration the financial pressures and risks as a system. • 13 December workshop to look at how the different programme across NEL will come together and look at interdependencies with other workstreams. • Improvement Networks and diagnostic work will link in and support the planning. • Final write up from workshop sessions will be shared and incorporated into future planning sessions. The following points were discussed: • Maximising value for money and supporting financial stability. • National metrics and possibility of including in plans. • Consideration for risks and how to be transparent and how the senior leadership team can support. • People who have lead local initiatives have moved around system and is a risk that learning will be lost. • Scoping best practice outside of NEL and learning from examples. • Governance structures that providers can work within would be helpful in terms of planning. The Community Health Collaborative supported the planning framework and the development of the plan for the 24/25.
5.	**Community Health Services Diagnostic** Pauline provided an update on the final specification for the NEL Community Services Diagnostic. Key highlights included: • The specification lays out the requirements for a supplier to provide a community services diagnostic for NEL ICS. This will provide an opportunity to transform services to better meet the needs of local people and address any variation/inequalities in the population of NEL. • The CHS Diagnostic will mirror the approach and build on the learning from MHLDA Diagnostic. • The CHS Diagnostic will give the Collaborative and NEL ICB a comprehensive picture of the current community health services, resources, value for money, quality of provision and outcomes for residents. • A procurement process will commence December 2023, with an award being made during Quarter 4, 23/24. The diagnostic can then commence by Quarter 1 24/25. • The Collaborative will be updated at the January 2024 on the tender outcome The following points were discussed: • Discussion around output and understanding of time and cost to the system as such a wide-ranging scope. The financial cap has been determined and based on financial envelope of learning from MHLDA Diagnostic. • The funding has been approved by the ICB and will be formally agreed at the Finance and Investment Committee. • Key stakeholder groups will be planned to help discuss delivery.

	The Collaborative supported and approved the CHS diagnostic in advance of a final version.
6.	**Improvement Networks** Pauline Goffin (PG) briefed members on the development of the Improvement Networks. Key highlights from the circulated paper included: • An update on the potential improvement networks and draft timelines to develop further and the opportunities and value in utilising improvement networks. • Improvements Networks will be made up of professionals, clinicians and subject matter experts who will use quality improvement tools and techniques for pathway transformation and service redesign across the whole system. • Will draw on learning from the Mental Health, Learning Disabilities and Autism Provider collaborative where this approach is reaping significant benefits such as Talking Therapies, Adults in Mental Health Crisis, Learning Disabilities and Children and Young Peoples Mental health and Wellbeing. • The Improvement Networks will develop on a phased approach, throughout the next 12 months focusing on key priorities for BCYP, Rapid Response, Falls, Community Nursing and MSK. • The first Babies, Children and Young People Improvement Network has already taken place and was well attended. The second session is planned for early 2024. Member discussed the following points: • Involvement of patients will be included in the Improvement Network and sharing of patient stories and experience. • Updates will be brought back to the collaborative on a regular basis as they start to be developed. • Selection of pathways to prioritise and how this will be determined. • Exploring learnings from national improvement networks. The Community Health Collaborative members noted the contents of the report and approved the principles of using Improvement Networks to drive through whole system improvements with the Community Health Services Provider Collaborative.
7.	**Community Collaborative Finance Update** Julia Summers (JS) briefed the Collaborative on the contents of the circulated report that gave an overview of the financial position for Month 6, highlighting that: • At month 6 there was a significant year-to -date overspend reported across the ICS (circa £88m). Whist the ICS has reported a forecast break break-even position in line with the operating plan there is a significant risk to the delivery of this. The risk to delivery of the forecast is estimated to be in the region of £55m. • As a result of the year year-to -date pressures a formal financial recovery plan (FRP) has been developed and work is underway to deliver financial savings across the system. • The ICS has significant underlying deficit moving into 2024/25 which means that the planning round will need to agree a set of assumptions that are supportive of the financial recovery plan principles. Once the full financial picture becomes clearer the Collaborative will need to prioritise areas for investment. • At Month 6, the ICB Community Health Service reported a year-to-date under spend of £1,244k and a full year forecast outturn of £1,484k. This is an improvement from the position reported in month 5. • This is an improvement from the position reported in month 5. Within the reported position there is an ongoing overspend on the discharge pathway, rehab and associated equipment in Barking and Dagenham, Havering and Redbridge. However, the costs of this in the inner London boroughs are covered by non-

	recurrent section 256 funding. This has resulted in an in-year non-recurrent benefit in 23/24. • Additionally, there are emerging pressures on activity-based contracts such as termination of pregnancy and insulin pumps. • SDFs for Ageing Well and Long Covid are both on track. • Key challenges and next steps have not changed and continues to be an ongoing piece of work. Discussion points included: • Have noted there are differences in reporting between finance and programme reporting. This is being worked through to determine correct positions. PMO colleagues are sense checking funding and schemes. • Discussed and agreed that it would be helpful to have spend position and track impact of spend and outcomes. • Provider spending of schemes would be beneficial. • Helpful to make distinction for this current financial year and how to approach next year to establish if there is an underspend and how much of that might be required to support the ICS overspend. The Community Health Collaborative members noted the contents of the of month 6 finance report and agreed that it is essential to have clarity on financial position. **ACTION**: Overall financial position to be shared and to include what is being spent in areas, slippage and impact of schemes.
8.	**Update from Delivery Group** Brid Johnson (BJ) verbally updated members, the Committee noted that: • PA consulting work and outcomes for planning for the future. • Finance and planning round and how to be clear on what is required for future funding. • Virtual Ward and link to Community Services. • Digital and variation of digital use in localities. • Waiting lists and exploring data following Deep Dives. • Emergency Care and winter planning. • To consider the governance and interrelationship between Delivery Group and Collaborative.
9.	**Any Other Business** No further business was discussed.

Date of next meeting: Monday 15 January 2024, 1500-1700

Minutes of the Primary Care Collaborative Sub-Committee

Wednesday 8 November 2023; 13:00 – 15:00; via MS Teams

Members:	
Mark Rickets (MR) – Chair	Primary care board rep
Jagan John (JJ)	Primary care board rep
Sarah See (SSe)	Managing Director of Primary Care, NHS NEL
Dr Ben Molyneux (BM)	Associate Medical Director for Primary Care, NHS NEL
Dr Mohammed Naqvi (MN)	General practice rep - clinician
Parvesh Patel (PP)	Community pharmacy rep - clinician
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 Khyati Bakhai (KBa)	Place based clinical lead (TH)
Dr Kanika Rai (KR)	Place based clinical lead (B&D)
Kath Evans (KE)	Director of Children's Nursing, Barts Health BCYP Clinical Lead, NHS NEL – for item 2
Chris John (CJ)	Interim Programme Delivery Lead – BCYP, NHS NEL – for item 2
Helen Jones (HJ)	Health Spot GP and NEL ICB CYP Mental Health Clinical Lead – for item 2
Siobhan Hawthorne (SH)	Programme Manager, NHS NEL – for item 2
Tom Margham (TM)	Co-Director EQUIP, NHS NEL – for item 3
Virginia Patania (VP)	Co-Director EQUIP, NHS NEL – for item 3
Rob Dickenson (RD)	Senior Finance Manager (Primary Care), NHS North East London – for item 4
Keeley Chaplin (KC)	Minutes - Governance manager, NHS North East London
Apologies:	
Henry Black (HB)	Chief Finance & Performance Officer
Johanna Moss (JM)	Chief Strategy and Transformation Officer, NHS North East London
Dr Sanjoy Kumar (SK)	General practice rep - clinician
Steve Collins (SC)	Director of Finance, NHS North East London rep for Henry Black
Dr Shabana Ali (SA)	Place based clinical lead (Redbridge)
Shilpa Shah (SSh)	CEO NEL Local Pharmaceutical Committee

Item No.	**Item title**
1.0	**Welcome, introductions and apologies**
	The Chair welcomed all to the meeting and introductions made. Parvesh Patel was welcomed as the nominated member from the pharmacy provider group. The meeting was not quorate however it was agreed the meeting would continue as there were no substantive decisions being 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 13 September
	The minutes of the last meeting held on 13 September 2023 were noted and will be circulated to members for formal approval. **Action:** KC to circulate for approval.
1.3.	Matters arising/action log
	Members noted the action log and agreed to close: ACT023, ACT025, ACT027, ACT028, ACT029 Updates for remaining actions were provided as follows: ACT026 – ARRS – this will be discussed under item 5.0 and action closed.
	The order of the meeting changed from this point.
3.0	**Primary care improvement week** - preliminary findings
	Virginia Patania (VP) and Tom Margham (TM) presented the early findings from the improvement week held in Tower Hamlets in October 2023. They ran five quality improvement events within one primary care network (PCN) to identify ways to improve patient care and experience. It focused on bringing all local services providers together (NHS, local authority, voluntary and community sector) in one space each day, to use real-time data and experience of patient demand and presentation to discuss and agree ways to quality improve patient care and experience. VP and TM highlighted the following: • The Bromley by Bow centre population health team conducted over 150 patient interviews during the week. • Out of 6500 patient contacts during the week over 700 opportunities for improvement were identified. • Principal themes were identified with the top two being an information gap where patients do not know where they are in the system after referral is made and care navigation. • It was found that some of Barts Health clinicians were operating on an outdated commissioning arrangement referring patients back to the GP rather than direct onward referral to their own diagnostic services. • There was some duplication of communications in A&E such as sending out two discharge reports. • Small scale improvement days will be planned across NEL. Members discussed the report and key points including: • What information and learning could be extrapolated to share out across NEL. • This fits into the interface work being done with place and acute. BM requested they share the emerging projects at the earliest opportunity. • Themes are likely to be common across the system and it would be worth sharing the outcomes more widely. • Of the opportunities that have been generated from this work, there is a need to find what will have the biggest impact. The Equip team can support up to 10 projects therefore the five practices will need to decide if they have two per practice or do they all decide on the 10 that will give most benefit to all. • Practices could decide to invest further which could then give an extra 8-12 projects.

	Members thanked VP and TM for their presentation and noted that it will also be taken to the GP provider group. The collaborative suggested that this is also presented to the Pharmacy provider group.
4.0	**Primary care finance report**
	RD provided members with a summary of the financial position and associated risks, at high-level (NHS NEL) but also providing some information at a Place level. RD highlighted the following: • The month 6 reported position had a forecast overspend of £24.4m. The ICB funded overspend predominantly relates to prescribing (£23m) which is driven by a continuation of month on month pricing increases. • The delegated budget is forecast to break even at present. • Approval was granted to continue with the Same Day Access (SDA) service for 3 years at a reduced annual value of c.£7.6m, equating to c.£3.8m for the last 6 months of the year. Funding has been identified but there remains a funding gap of £0.6m. • Key risks include demographic growth, Additional Roles Reimbursement Scheme (ARRS) and Prescribing. This includes practices not getting their claims in on a timely basis. There is slippage in prescribing of £4-5m. Discussion points included: • GP list sizes are continually growing and beyond estimates and how much of prescribing is affected by extra growth. Budgets are based on list sizes and not growth. • The budget was set based on month 10 timescales to get budgets and operating plans running but there have been continued growth month on month. Medicines Optimisation have a steering group that will look at the delivery of the cost improvement programme (CIP) and the collaborative may wish to receive that information. • NHSE London has asked for more work to be done on the overall declared year end deficit position as reported at the ICB Board. • A financial recovery director has commenced in post and actions taken include higher controls and double lock system for expenditure over £50k. A Finance Recovery Board has been established. • The dental budget has underspent so could there be creative ways to use this underspend. • It is important to be able to view place-based data to see finances at each place and compare income streams and the situation. **Action:** RD to include finance data for each place to compare income streams. The sub-committee noted the financial update report.
4.1.	Primary Care System Development Funds (SDF) briefing
	SSe provided members with an update on the NEL approach to delivering the 2023/24 System Development Funding (SDF). A review of the SDF priorities will ensure they align with the ambitions, improvements and change required to deliver the primary care access recovery programme, fuller ambitions and long-term workforce plan. The review will look at the reduced allocation of funding and how to make best use of it. The next review with NHSE will take place in January 2024. **Action:** Place based colleagues were asked to share with BM any reflections on the impact on digital first and the training hub, including what is working well, what is not working well and any gaps. **Action:** An update will be added to the forward planner.

	Members noted the update.
5.0	**Joint report from the managing director of primary care and (associate) medical director for primary healthcare**
	SSe updated members on the report highlighting the following: • Last year there were £4.5m late claims from PCNs for ARRS. This year the ICB will not be in a position to cover these therefore the teams are calculating what these claims are likely to be. The ICB will only receive 60% of the funding and the rest will be based on drawdown therefore it is important PCN claims are up to date. • Any PCN that goes above its budget will be at risk as the ICB cannot cover above its allocation. • This will change from a DES to mainstream funding next year. • Work on the primary care risk register is being done. There are 15 high level risks and the primary care team will work on breaking these down and to look at these by place and will also capture risks from Dentistry, Optometry and Pharmacy. • Work is being undertaken to support London Living Wage accreditation and establishment of a Freedom to Speak Up Guardian service for primary care BM noted the following: • A lot of work has taken place on the NEL primary secondary interface. The first meeting of the interface group will take place on 22 November using the existing Clinical Advisory Group with an expanded membership. The group will set the priorities which will likely include the primary care access plan. This is a NEL level group and places will be setting up local interface groups. City and Hackney and Tower Hamlets have progressed with theirs and BM asked if other places could confirm their own place local interface groups are being set up. • Prospective record access to primary care patients became a contractual requirement from 31 October. Nearly 80% of practices have now turned this on. There are now 48 practices that have not yet gone live and we are writing to them to ask if they require support to resolve any issues. • A workshop on the Same Day Access workstream has been arranged for 14 November. Members discussed the issues noting the following: • Communications from the primary care team could be improved by including staff names and direct email addresses. When there are issues with practices such as practices being closed during working hours, it would be better if place leads could receive that information to liaise directly with the practices in the first instance. **Action**: To send PCN contacts to community pharmacy provider representatives for information. **Action**: BM was asked to add the following to the GP provider group agenda: • Undertaking of medical examiner work and the sharing of the pilot work that has taken place in City and Hackney. • Right Care, Right Person (RCRP) – the GP provider group to consider if there has been any impact on primary care from the police no longer attending health related calls. Members noted the report.
2.0	**NEL Babies, Children and Young People (BCYP) Programme: Primary Care Priorities**
	Kath Evans (KE) and the programme team provided an overview of the BCYP programme which sits within a portfolio of programmes designed to delivery the integrated care strategy and its key priorities. The programme is overseen by the NEL BCYP Executive Board. KE outlined the following:

	• Themes have been identified on how it can work in partnership with primary care such as access to services; preference for home-based/community care; youth-friendly primary care; preventive focus; and support for long-term conditions. • A big concern is primary care registration with an estimated 12k unregistered children from data provided by Child Health Information Services. The team would like to understand more on the reasons for this and what support may be needed to improve this. • There have been some integrated child health pilots across NEL which has been good and want to grow this agenda further. • There are some prevention opportunities. Dental extraction is one of the highest reason for hospital admissions so the team are keen to work with dental colleagues to look at this. Another area of prevention to look at relate to long term conditions such as asthma and diabetes. • Helen Jones (HJ) provided an example of work in Tower Hamlets that has looked at service provision and commissioned services and linked them together to provide an integrated service for young people. Services include sexual health, substance misuse, mental health counsellors, speech and language therapists. This is to reduce silos and a model that Newham and other places are also keen to launch. Members discussed the issues raised and key points included: • More children may be registered but there may be data inaccuracies when inputting the data into the EMIS system causing them to appear unregistered. There is a need to reconcile the data. KE advised that in Newham 6000 children were found to be unregistered so there is a deep dive taking place to understand the reasons for this. • BCYP is a priority for places, but each place may have different needs to fulfil dependent upon the local demographics. There is a Director of Children's Services, Director of Public Health and a Director of Place on the Executive Board and they would also like to strengthen this with a primary care representative. • The collaborative can use this information to inform discussions with practices and PCNs of its importance and to consider this when looking at resource allocations but there are a number of priorities that must also be considered. Members can also highlight the work in Tower Hamlets to raise the profile of young people's rights under the 'You're Welcome' standard. **Action**: The collaborative agreed to support the programme by circulating the work being undertaken on child registrations to primary care colleagues as well as highlighting the work being done in Tower Hamlets under the 'You're Welcome' standard and the integration of child health and championing the programme generally. **Action**: KE and team to present this work to the provider groups **Action**: The Joint chairs to discuss and nominate a member to represent the collaborative at the BCYP Executive Board. The report was duly noted.
6.0	**Provider groups**
6.1.	General practice provider group
6.1.1.	MN provided members with the update on the GP provider group which requested the following from the collaborative: • The group had asked for the collaborative to be informed of the primary care improvement week, MN will report back discussions from this meeting. • The group would like to receive further communications on Operose once information is available. • The group asked to be sighted upon the work being undertaken at Herts and West Essex on the conversion of APMS into GMS contracts and how this is been

	communicated with the national team. SSe advised that a request for this information has been sent to NHSE but there will be changes to procurement and commissioning.
6.2.	Pharmacy provider group
	PP provided feedback from the pharmacy provider group advising that the September meeting discussed the minor ailment scheme and to encourage more GPs to sign up to this as well as overall collaboration with the GP forums. The October meeting was a workshop on the medicines supply shortages and discussed mechanisms that can be put in place to manage this and reduce wastage. **Action:** PP to arrange for an item to be discussed on the prescribing challenges including CIP prescribing and medication wastage at a meeting of the GP provider group and the pharmacy provider group.
7.0	**Items for exception report to PHIC**
	Items to feed up to the PHIC are: • The risk on capacity to deliver – prescribing CIP and ARRS claims • Advise on dental budgets and any flexibility in relation to any underspend reported • QI EQUIP work • An update on the primary secondary Interface work **Action:** As members of PHIC, JJ and JM to consider how they will feed salient issues discussed at PHIC back to the collaborative. **Action:** KC to ask Charlotte Pomery for a programme of themes they are planning at PHIC that they would like the collaborative to focus discussions around and feed back.
8.0	**Any other business**
	None raised.
9.0	**Items for information**
9.1.	Meeting forward plan
	Noted.
Date of next meeting 10 January 2024	