

**Primary Care Directorate Management Team Meeting**

**Minutes May 2021**

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| **Date:** | **Wednesday 23rd June 2021** | **Time:** | **14:00-16:30** | **Meeting No** | **10** |
| **Location:** | On Microsoft Teams |
| **Chair:** | Liz Dawson |
| **Note Taker** | Marion Savariaud |

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| **Present** |
| **Name** | **Title** |
| Liz Dawson | Medical Director for Primary Care  |
| Louise Cole | Practice Manager – Leighton road surgery |
| Mohit Venkataram | Executive Commercial Director |
| Fahima Khan | Admin Manager at HE1 (Deputizing for ED) |
| Alaa Alhamoud | Finance Business Partner for PC |
| Louise Little | Practice Manager – Newham Transitional practice |
| Sri Putti | Data and Income Manager for PC directorate |
| Emily Humphreys | Public Health Registrar |
| Nicola Hoad | Development Manager |
| Shade Olutobi | People Business Partner – Primary Care  |
| Keely Smith | People Relations Advisor |
| Andreea Tudosa | Primary Care Communications specialist |
| Asad Khan | Interim Practice Manager at Cauldwell Medical Centre |
| Joanne Alder-Pavey | Quality and Compliance Lead |
| Sara Marsili | Communication Officer for PC |
| Taiye Aro | Marketing Manager |
| Ali Khan | Deputy Practice Manager for Greenhouse |
| Asad Khan | Interim Practice Manager at CMC |
| Alex McGarvey | Lead Nurse at LRS |
| **Apologies** |
| Marina Muirhead | Director for Primary Care |
| Sultan Ahmed | Outreach Practice Manager |
| Emma Dirken | Lead advanced Nurse Practitioner – Health E1 |

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| **No.** | **Agenda Item** |
| **1.** | **Welcome, Introduction and Apologies** |
| 1.1 | Liz Dawson welcomed the group and introductions were made to Sara Marsili who is the new Communication Officer for Primary Care.The Minutes of the last DMT were agreed as an accurate record. |
| **Spotlight on the DMT Annual plan** |
| **2.** | **Capacity and Demand** |
| 2.1 | Nicola Hoad explained they are still working out on what information needs to be captured.The clinicians are currently capturing the interruptions and how much time they spend on admin. Nicola is also working with Victoria at CMC on some of the admin side. This is still an ongoing work and they are still finding new areas of work that need to be added.Nicola is confident they should soon have a good plan on the basics of what the interruptions are, and how the time is spent. It will be an overview of it and will not be perfect. They will give things a go and see what happens and will monitor and tweak things where and when needed. |
| 2.2 | Liz summarized for everyone that the idea was to better understand CMC’s demand to be able to match capacity. She explained that demand has a very predictable variability.They have had weekly meetings with CMC since April and kicked off with weekly meetings with LRS last week. It is interesting work, although the hardest is in trying to measure. A lot of the data needed needs to be collected manually.There are now at a point of making small-scale tests of change to see if they can improve everybody’s working day. |
| **3.** | **SPR in Public health to be assigned to primary care from May via the ELFT PH team to do some specific work on health inequalities** |
| 3.1 | Emily is a Public Health Registrar with a background in Health inequalities. She used to run the Greater London authorities’ health inequalities function. She will be at ELFT as part of her training until December 2021 and will be supporting the primary care directorate.Public health functional health is fairly new at ELFT and Emily wants to pilot a way for the directorate to work with other clinical teams and working out what kind of public health support looks like and how to make sure that they bring in a population health focus and a health inequalities focus across everything they do. Health inequalities are a big planning priority both Nationally and within ELFT as part of population health.Health inequalities are not just about things driven by biological characteristics, but more about what is avoidable, unfair, and systematic differences in health that can be acted upon where our society and processes have created inequalities.Emily’s question to all: “What do you want to do on inequalities in the primary care directorate?”Link to paper “ Addressing health inequalities in Primary Care”The group went through the paper submitted by Emily. The items discussed were:* The three initial options for a “deep dive” project to investigate and address an aspect of health inequalities in primary care, as part of wider work to strengthen ELFT’s population health approach.
1. investigating and addressing inequalities in patient access and experience in Bedfordshire practices
2. investigating and addressing inequalities for people with protected characteristics in specialist East London practices
3. investigating and addressing the impact of changes arising from the COVID-19 pandemic on equality of service uptake across the Primary Care Directorate
* What the DMT is asked to do
* The purpose of the paper
* Policy and planning context
* What are health inequalities?
* The potential role of primary care in reducing health inequalities
* The initial parameters for the project – What it will need?
* Thematic areas arising from the DMT (Access inequalities, hidden inequalities, digital/race/gender/LGBT/history of abuse inequalities, data quality, service linkage and referral patterns)
* Project governance
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| 3.2 | Emily asked for the DMT’s feedback in regards to the questions posed in the paper. From their experience, she asked them to think about who might be the groups underserved within the ELFT population.**Gender and Gender reassignment** (Louise Little) * Patients who had gender reassignment – Not always very clear where they stand in the community, not many services or groups to support them. Treated unequally (ex: woman born as a man who is pre-op and has been put in a male only hostel).
* Lack of information around some isolated cases
* Louise L wants to do some work around gender and gender reassignment alongside HE1. Alex McGarvey also agrees there would be work to do on that across Bedfordshire.

**Languages and Ethnicity** (Louise Cole/Louise Little)* Having a more robust system around languages
* Lot of patients in London do not have English as their first language. Even if they speak, it does not always mean they can read it or write it. They are spending a lot of money on comms and forms that these patients might not understand. Interpreters and face to face interaction will always be available, but could there also a support group for these people where they could learn English and be given the tools on how to fill in forms.

**Groups of patients or potential patients who are not getting through services at all**Louise Little mentioned that some of it is the patient’s choice. (Ex: a big group of patients have overstayed their visa in UK and are very scared to approach services thinking the police will be called and they will be deported.)As a result, the patient presents at the last minute once their condition has worsened. How to prevent that and get to them first before they go to A&E?There is some work to be done around breaking social stigmas and rumors to get patients through the doors.**Adults - learning disability** (Alex McGarvey)* They have many adults coming forward thinking they have autism or are somewhere on the spectrum.
* There are no accessible services for adult people with newly diagnosed learning disabilities.

**House bound patients** (Alex McGarvey)* Feeling that these patients are not served as well as the ones who are not house bound.
* But also worth recognising that if a patient rings up and request a home visit, the patient will get it on that same day; whereas if the patient rings and request an appointment on that same day, this might not be possible.
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| 3.3 | Emily thanked the group for their contribution. She summarized the groups identified of specific patients who are at risk:* Gender reassignment
* People with substance misuse
* Migrants
* Homeless people

The following gaps and widening inequalities were identified:* Childhood immunization (many Roma parents do not like to vaccinate their children)
* Screening services (many of their Roma patients do not like screening)
* Screening for mental health issues or learning disabilities (Some patients do not like receiving those invites because they assume they are not concerned)
* Children with mental health issues – Alex explained there is a big explosion in cases lately and would want more integrated work with schools and work being done in the surgeries.
* Physical health intervention for patients who had a previous existing mental health condition. These patients have been disproportionately affected by Covid, meaning their symptoms have worsened and that they are even less likely to engage with physical health checks and screenings.

Mohit also mentioned the fact that there is a lot of evidence coming out about late presentations of people with cancers and elderly population being excluded because of the digital age we are in. Mohit has not seen any data from our practices proving otherwise and suggested this might need to be looked into. |
| 3.4 | **Next steps**Emily asked the DMT for a decision today on whether they want to do something that focusses specifically on CMC and LRS or just on the East London practices – or work across the whole of the directorate?The group agreed to work on something across the whole directorate. They want this piece of work to be something they achieve all together.Liz agreed that taking this approach might be wiser. She explained that they normally divide the practices (BLMK and East London) because of the commonalities in patients they see; but wonders whether they are creating an inequality for their total patient group by doing so. Instead they should focus on:* What are the broader inequalities that are experienced by all the patients we look after?
* Work towards having a positive impact for the 36,000 people under our care to tackle an inequality that we know was experienced by everybody (Ex: transphobia)

**Volunteers for the project team:*** Louise Cole
* Louise Little
* Sultan (Community engagement lead for East London & OT practice Manager)
* Totei (Community engagement lead for bedfordshire)
* Joanne Alder-Pavey
* Nicola Hoad
* Marina and Liz as project sponsors

Emily emphasized that they will need someone to drive the project forward. Emily is here to support but the project needs to be owned by the practices.**Action: Emily will set up a group with all the people who volunteered to do a piece of work and come back with a tighter looking project at the next DMT.** |
| **4.** | **Staff survey working group update** |
| 4.1 | Shade shared her paper with the group and explained that they have had three staff survey working groups so far. She is now putting together an action plan based on the information she received.Link to the People & Culture reportHeadlines from info received so far:* Well-being / team work / Safe environment, bullying and harassment are the three areas that always show up on results
* There are gaps - Scores for PC were lower than scores received for the Trust overall.

Responses received to “what can be done to improve these results?”* Number of suggestions about addressing workload
* Having well-being conversations and support
* Staff appreciation and acknowledging the work being done
* Team work, daily/weekly huddles
* Implement feedback from staff to direct managers and senior managers – feedback to be taken forward.
* Team bonding, activities

**Action: Shade to circulate the “improving staff survey” action plan once it has been seen by seniors and directors.** |
| **5.** | **Service plan – CMC and Outreach service** |
| 5.1 | Sultan was off sick and not able to present his submitted service plan for the outreach service.Link to OR service planAsad did not have CMC service plan ready and could not present. |
| **6.** | **New practice leaflets – update on progress** |
| 6.1 | Sara needs to identify the project lead for the new practice leaflets. She explained that the work was started internally and that they would now need to assign the work to an external team of designers to ensure consistency.* Taiye (Marketing Manager) will be working with Sara on this project.
* Agency is up and running and ready to go. An initial draft of the brief has been created
* Key aspect of this work will be on the content which will be the main driver on how these new leaflets are laid out and presented
* They do not have that content at the moment and they are proposing for each practice to nominate a liaison with whom the communications team will work with directly.

Once the liaison with each practice is set, Taiye is confident they will be able to have a first draft of the new design before the next DMT. |
| 6.2 | Nicola Hoad explained that Andreea and her had already gathered a lot of content and drafts of what is going where. She asked Taiye and Sara to get in touch with her after this meeting.**Action: Taiye to liaise with Nicola for the information she already has.****Action: Once the first draft of the leaflet is created, Taiye to send it out to each practice Manager for review as they might have a different approach.****Action: Practices to get feedback on the draft leaflet from their patient groups and get input from service users.** |
| **Feedback from the DMT Subgroups** |
| **7.** | **Update from the DMT performance Subgroup BLMK** |
| 7.1 | The meeting could not take place as a result of Marina not receiving the minutes or the performance packs on time. **Action: Nicola Hoad to make sure that the dates are in the diary and that the agendas and minutes are ready.** |
| **8.** | **Update from the DMT performance subgroup – Inclusion health** |
| 8.1 | Their last meeting was cancelled and they did not get a new one rebooked. The next meeting will take place on the 16th July.**Action: Nicola Hoad to make sure that the dates are in the diary and that the agendas and minutes are ready.** |
| **Signed off and for ownership and implementation at a service level – Verbal update** |
| **9.** | **Handover to services for implementation and ownership – Admin induction pack** |
| 9.1 | Nicola Hoad still needs to check with each practice whether they have the most up to date service specifics but she does have the structure of the induction pack with:* ELFT section
* Primary Care section
* Section about the role

Nicola stressed the fact that the practices will be responsible for the maintenance of their own section, the rest will be stored on the joint drive. For any new jobs coming in the future, there will be the option to pick the file needed, depending on the role and the practice it applies to.Nicola is still working on reducing duplications within the pack and to make it more rapidly accessible without the person having to read through irrelevant sections in order to find what they need.Packs should be finalized by the next DMT.**Action: Nicola to send her final version to all practice managers asking them to proofread it and let her know if changes are needed.** |
| **10.** | **Handover to services for implementation and ownership – Nursing induction pack** |
| 10.1 | Alex McGarvey shared her induction template. The idea of that general practice nursing template is to sit within the induction pack that will be practice specific. Practice Managers will need to take out the role of administrator bit and pop this nursing bit instead. The same is to be done for the HCA competencies.Link to the Nursing induction template to be embeddedLink to the HCA competencies to be embeddedThis is to ensure that Nurses get a comprehensive induction into practice and for learning needs to be identified. This is also to ensure that they have the competencies signed off and that people are working safely within their scope.* Each new Nurses will have introductions with key members of staff in the practice, at Directorate level and externally (CCG links, PCNs etc).
* Section about the Nurse career’s aspirations and how we can help them achieve these.
* Sections about Trust strategy and vision
* Section on clinical competencies – evidence of certificate needed
* Section on supervision
* The competencies that do not apply to a specific role can be shaded out.
* Section on key information with basic explanations and useful resources (CQC, QOF etc)

This template has been looked at and signed off by all the Lead Nurses from all practices. Alex is confident that this can now be used for any Nurses starting out. |
| **11.** | **Locum Doctor induction pack – template for local use** |
| 11.1 | There is a Primary Care GP meeting on Friday that Mohit and Liz will attend. Liz think it is best for them to discuss this template with all the GPs at that meeting instead.Liz will feedback at the next DMT. |
| **Standing items** |
| **12.** | **Performance packs** |
| 12.1 | Nicola informed that all packs were created but bits were missing. She explained that this is a struggle to get the finance details on time for DMT. The packs will always be available on the joint drive where a historical record is kept. |
| **13.** | **Finance report** |
| 13.1 | Alaa presented his report to the DMT. The main highlights for each practice:Link to the Finance report for May 2021The Directorate currently reports an overspend of £228k as at the end of May 21. This represents an adverse movement in month of £73k.Health E1* Position - £26k Underspend
* Represents a favourable movement of £19k in month.
* Mainly driven by 4.06 WTE of substantive vacancies in the service. Vacancy saving of £42k is partially used on agency and bank staff at £29k and £1k respectively.
* Non-pay is currently reporting an overspend of £3k YTD, mainly driven by £4k furniture spend.
* Premises costs - premises claims to Tower Hamlets CCG for the re-imbursement of rent, business/water rates and clinical waste have been accounted for and this is reflected in the accounts.

Newham Transitional Practice* Position - £16k Underspend
* Represents a favourable movement of £12k in month.
* Mainly due to underspend on pay by £13k in month. The year to date substantive saving factor is £23k, being partially offset by £3k spend on agency.
* Non-pay is currently reporting an overspend of £4k, mainly on drugs which is being offset by income and vacancy savings.
* Premises costs - Premises claims to Newham CCG for the re-imbursement of rent, business/water rates and clinical waste have been accounted for and this is reflected in the accounts.

 Greenhouse* Position - £23k Underspend
* Represents a favourable movement of £14k in month.
* Vacancy savings of £27k is being partially used to cover agency.
* Non-pay is currently reporting an overspend of £10k year to date. The main reason for this is due to cost pressures on Security payments of £12k YTD. It is been understood that the practice and Estates has put in an alternative security plan to cease the use of the security guard.
* Premises costs - Premises claims to City & Hackney CCG for the re-imbursement of rent, business/water rates and clinical waste have been accounted for and this is reflected in the accounts.

Homeless VP Service* Position – £1k Overspend
* Pay spend year to date is £106k.
* Medical - £60K
* Nursing - £35k
* Admin - £11k

Management* Position - £32k Underspend
* Represents a favourable movement of £16k in month.
* Mainly due to vacant posts and slippage in recruitment. Vacancy savings of £37k is being used to cover bank staff which total £4k year to date.

Leighton Road Surgery* Position - £221k Overspend
* Represents an adverse movement of £85k in month.

The pressure on pay is £201k YTD:* Substantive adverse variance - £45k
* Agency - £59k
* Bank - £100k
* Recruitment is currently taking place for salaried GP’s, so reliance on locum GP’s should reduce if recruitment is successful.
* Non-pay is currently reporting an overspend of £23k year to date. This is mainly due to the costs of CQC and Avalon Cleaning.
* Income reported is £446k year to date. The income assumption is based on the Income Model.

Cauldwell Medical Centre* Position - £110k Overspend
* Represents an adverse movement of £53k in month.
* Vacancy savings of £50k is being used to cover both agency and bank staff which total £181k year to date. Pressure on pay is £130k YTD.
* The new proposals for the substantive nursing staff have now been approved so agency spend for nursing is expected to reduce going forward. Recruitment is currently taking place for salaried GP’s, so reliance on locum GP’s is expected to reduce as the year progresses.
* Non-pay is currently reporting an underspend of £13k year to date which is being absorbed by the pay overspends.
* Income reported is £164k year to date. The income assumption is based on the Income Model.

General Actions* Monthly meetings are taken place between Finance and the Service/Practice Managers. These meetings will focus heavily on enhanced services and unpicking the budgets around income and expenditure.
* Monitor income and report to Finance all expected income by populating the Income Model with the relevant information.
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| **14.** | **Agency spend** |
| 14.1 | Joanne Alder-Pavey presented her paper and highlighted the following:* 1283 hours of agency usage during May 2021 (CMC, 581.5 / HE1, 277.5 / OT, 225 / LRS, 173.5 / GH, 15 / NTP, 10.5)
* Usage has fluctuated through Oct20 to May 2021, at its highest in February and March 2021

Link to the agency usage report for May 2021 |
| **15.** | **Report from the Data and Income Manager** |
| 15.1 | Sri is working on all the projections for the five practices which are proving quite tricky as there are various CCGs and PCNs.A draft report was sent to Louise Cole and Marina for their review and feedback. The final template will be ready for the next DMT.Some of the processes have been changed:* Now encouraging all practices to submit CQRS by the fifth of the month so they can be processed for payment during the same month.
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| **16.** | **People and Culture report** |
| 16.1 | Shade shared her report with the DMT. Her main highlights were:* Sickness reporting summary for June – sickness rates are high and showing primary care to have the highest percentage within the whole trust. (This is due to the fact that the directorate has got smaller teams)
* More short term than long term sickness – more monitoring needed
* Highest type of sickness is to do with anxiety, stress and depression. There is a need to do something around supporting staff.
* Covid risk assessment – This need to be brought up again as the previous results were not too good. Shade will be contacting Managers who have outstanding Covid risk assessment.
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| 16.2 | Louise Little explained that she had a few staff members off with bereavement leave and that she had no other option than to select “stress” as the cause of their absence. She asked Shade whether they were thinking of adding “bereavement” to the option list.Louise agreed to catch up with Shade after this meeting. |
| **17.** | **Update on recruitment / Wider ELFT updates** |
| 17.1 | Many roles are out to advert at the moment:* Practice manager at CMC
* Lead Nurse at CMC
* Bank GPs and salaried GPs at LRS
* Operations Manager

Liz mentioned the fact that the services are getting a much higher levels off demand as well as A&E services across the country. No one knows how long it will last. Liz started a conversation with the other medical directors in Bedfordshire and Milton Keynes to identify people who can help and how to communicate with people so they know who can help them.Liz would want the group’s input if they feel that there are other bits of the health and care system where we could develop better working relationships. |
| **18.** | **Any other business** |
| 18.1 | Building issue at LRSLouise Cole reported that they have a serious building issue at LRS. There have a rat infestation and Estates are aware. The path has corroded meaning they are able to get under the path and into the building. The roof of the building also has a leak.Louise stated that the lease terms & conditions says that ELFT is responsible for all repairs. They are in conversation with Estates and the Landlord about renewing the lease and them giving some funding to bring the building back up to a good state. |
| 19. | **Date of the next DMT: Wednesday 28th July 2021** |