MEETING NOTES - WARWICKSHIRE NORTH PLACE EXECUTIVE

Thursday 9th June 2022

09:00-11:00

MS Teams Meeting

PRESENT		
Name	**Initials**	**Title**
Jenni Northcote	JN	Chair - Director of Strategy, Service Improvement and Partnerships, GEH
Salmah Mahmood	SM	Programme Manager – Warwickshire North Place, GEH
Becky Hale	BH	Assistant Director of People, Strategy and Commissioning, Warwickshire County Council
Tracey Sheridan	TS	Associate Director of Operations Swft
Martin Sandler	MS	Deputy Medical Director GEH / Associate Medical Director Swft
Steve Maxey	SMy	Chief Executive, North Warwickshire Borough Council
Elouise Jesper	EJ	GP Partner and PCN CD in Nuneaton
Jane Coates	JC	Service Manager, Inequalities, Public Health, WCC
Asif Atta	AA	CovWarks
Amar Kacchia	AKh	LMC Representative
Ryan Coffey	RC	Project Manager, GEH
Kevin Jackson	KJ	Inspire Energy
Becky Millward	BM	Patient Experience Manager, GEH
Giles Piercy	GP	Locality Matters
Maxine Moss-Black	MMB	Programme Manager, Help Force
Rosslyn Young	RY	Assistant Director of Nursing & Quality, NHS England & NHS Improvement Midlands
Tim Hamson	TH	Head of Business Intelligence (PHM), CCG
Alexis Bradshaw	AB	Optum
Mand Kaur	MK	Optum
Debbie Dawson	DD	Coventry City Council
Sam Young	SY	Programme Assistant – WN Place, GEH
Name	**Initials**	**Title**
David Eltringham	DE	Managing Director, GEH
Chris Bain	CB	Chief Executive for Healthwatch, Warwickshire
Shade Agboola	SA	Director of Public Health, Warwickshire County Council
Blaire Robertson	BR	Programme Director, UHCW
Daljit Athwal	DA	Executive Director of Nursing, George Eliot Hospital
Rupin Somaiya	RS	Deputy Medical Director, George Eliot Hospital

Chris Lonsdale	CL	Director of Finance, CCG
Catherine Free	CF	Medical Director, George Eliot Hospital
Robin Snead	RS	Chief Operating Officer, George Eliot Hospital
Sharon Binyon	SH	Medical Director, CovWarks

Item No.	Notes
1.	**Apologies** As detailed above. **Welcome / Introductions** JN welcomed partners to the meeting.
2.	**Review of the Minutes and Action Log from the Previous Meeting** The minutes from the previous meeting were taken as an accurate record of June's meeting. **Action Log;** Action 5.5.1/5.5.2 - Dashboard – SM confirmed that work is on-going with the named lead provided by TS to incorporate information into the dashboard and that is going live. The Dashboard will be presented to partners at the July WN Place Executive Meeting. Action 3.4.1 – SM to link with Eleanor Cappell – SM has spoken with Eleanor with a further meeting scheduled. 5.10.1 – Atherstone Hub – JN to link with Roma Holland in terms of the local estates forum and if this is progressing or has been re-constituted and how this links into this conversation from a local estate planning perspective.
3.	**Matters Arising** There were no matters arising.
4.	**Sustainability – Going Green at Place (KJ)** WN Place Exec meeting 20220608.pc JN introduced KJ from Inspired Energy and explained that this item is in relation to how all NHS organisations have a requirement under a legislation and contract, to develop their green plans in relation to becoming carbon neutral and in the context of each organisation developing their plans and also the fact that there is some system work in the Coventry and Warwickshire footprint. It was felt that they didn't want to miss joining up all the organisations plans at Place and then feeding these back into the system and also to think about what opportunities there are in terms of wider partner working with Place.

KJ talked partners through the attached presentation with the main points being;

- KJ asked to think about what actions they could/should be doing to support the journey 'not net zero'.
- People may think fires, floods, strange weather patterns may happen miles and miles away but there are more and more instances of these happening closer to home.
- When linked back to health, these extreme weather conditions have got a connection to health, even if you only look at air quality for instance, there is a statement that 900 people were killed last summer by heat waves while nearly 18 million patients go to a GP practice in an area that exceeds the World Health Organisation's air pollution limit.
- KJ referred to a statement by Sir Simon Stephens in relation to delivering a 'Net Zero' National Health Service, the climate emergency is also a health emergency. Unabated it will disrupt care and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated. We therefore make no apologies for pushing for progress in this area while still continuing to confront coronavirus.
- What is greener NHS?
  - As the largest employer in Britain, responsible for around 4% of the nation's carbon emissions, if this country is to succeed in its overarching climate goals the NHS must be a major part of the solution
  - Carbon footprint –2040 - For the emissions we **control directly,** we will reach Net Zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
  - Carbon footprint Plus –2045 - For the emissions we can influence, we will reach Net Zero by 2045, with an ambition to reach an 80% reduction by 2036 to 203
- The Timeline – What must be done by when?
  - Every NHS Trust had to produce a green Plan by 14th January 2022 and they then had to be collated at system level with them submitting these to NHS England by 31st March
  - In the main they have been done to varying degrees of completeness and there is a meeting expected with NHS England later this month with some feedback on the plans at system level expected in July.
  - Interim stages – the control of emission 80% by 2028 and then for the influence of emissions 80% by 2036.
  - In the meantime, it is about doing little bits.
- A green plan is a document that brings together all of the different activities that a trust and a system can take to build that momentum and movement to take everybody on that journey.
- The plans are broken down into 9 areas of focus, these being;
  - Workforce and System Leadership
  - Travel and Transport
  - Medicines
  - Sustainable Care Models
  - Digital Transformation
  - Supply Chain and Procurement
  - Estates and Facilities
  - Food and Nutrition
  - Climate Change Adaption
- Each of the areas of focus for trust and system level should have a named nominated lead for that.
- KJ talked through an image that shows the emissions that we put into the atmosphere just through day-to-day activities.
- An anomaly in the NHS IS THE Anaesthetic gas use which is a major factor.

- The controllable emissions predominantly reside from the supply chain and are referred to as scope three, Procurement have a big part to play in this area.
- Anchor institutions – no individual person or individual organisation can do this on their own so this is a truly collaborative exercise and the notion of an anchor institution goes hand in hand with the notion of place, the sense of place and the meaning behind anchor institutions is that it's a body that's anchored in place that people look to for reason and purpose.
- This is about trying to get better outcomes for the region particularly around health.
- How do we bring about change?
    - There is a typical action plan that exists around trust and system level with a list of actions and who is responsible for these and who is going to make it happen.
    - Get to know your action plan and get involved and take people on that journey with you.

Questions/Comments

JN thanked KJ for the presentation and explained that they particularly wanted this item on the agenda as they really want to make that connection at place around the anchor piece and what Place can be doing and what are the messages they are delivering as a leadership at place around this agenda and also bearing in mind the wider connectivity issues with the health and wellbeing partnership and how this is picked up.

JC suggested KJ link with Matt Whitehead in the chat box, Matt is in the programme management team but is WCC's net zero manager and is responsible for the development of a lot of WCC's strategies and action plans.

JN proposed next steps to partners, with these being;

- A commitment into embedding the Sustainability question in relation to any of our plans and delivery programme to enable that they ask the questions, is there an opportunity within this piece of work that is being taken forward to consider a positive sustainability impact and the opposite of that being thinking about if it is going to make a negative Sustainability impact. **This was agreed by partners.**
- A joint bid has been submitted with South Warwickshire Foundation Trust around trying seek some funding to support behaviour change campaign which is about looking at what drives people to be motivated and about making small changes around a sustainable lifestyle and this could be an opportunity for partners to think about that in terms of a communications campaign and a culture change and could be something that could be expanded at place if the bid is successful. JN proposed that this be bought back for discussion at a future meeting. **This was agreed by partners.**
- There is a lot of activity in terms of communications that GEH is going to be looking to go on the back of things such as Asthma Week, Air quality week etc. and using those things to prompt conversation in terms of Sustainability so the proposal is that this is something that could be done across place rather than a single organisation by linking in with various different comms in different organisations. **This was agreed by partners.**
- There maybe other colleagues around the table, particularly Primary Care, where JN is unsure about how the agenda fits that PCN/Practice level so there maybe an opportunity to pick this up as a piece outside of the meeting. **This was agreed by partners.**

EJ wanted to highlight the work that the networks are currently starting particularly around asthma. EJ thought it was a fantastic illustration of how if you start improving Sustainability and environmental impact then you improve health outcomes. A patient with Asthma who is not well controlled will be using the wrong inhalers and maybe not have the most up to date advise about what they are meant to be using so the work they are doing to swap inhalers where

	appropriate to more environmentally friendly versions but also the real message is if someone is using their inhalers correctly then they are going to be reducing the carbon footprint because their using less of the relievers. EJ felt it was about good news stories such as this. AK echoed what EJ said and informed partners that it is part of the IIF contract to have greener inhalers. AK felt that they didn't want the cost resource on the NHS for swapping inhalers to different one's then just a couple of week's later swapping 60% of them back. AK felt it was better to start from the beginning with new asthma patients. JN suggested that the good news stories would be a good way of sharing what people are doing.

5.	**Volunteering Update – BM**
	
	Overview BtHP for WN Place Exec 9th Jui
	
	BM introduced herself as the patients experience Manager at GEH and was supported at the meeting by Maxine Moss-Black and Giles Piercy from Helpforce.
	
	BM shared details with partners of the back to health pathway programme of work, with the main points being;
	• After a presentation BM gave a while ago at this meeting, partners asked her to go away and think about how volunteers might be able to help release pressure on a wider range of services outside of the George Eliot Hospital and with massive support from Helpforce they are now able to share details of this programme of work.
	• The back to health pathway responds to pressures in the system, like increased waiting lists, DNAs, length of stay and the need to increase flow because all of this is putting massive pressure on community and social care also.
	• The model is about working with partners to identify and create volunteering opportunities that reduce some of that pressure, create some capacity and really build on community assets and strengthen local communities.
	• Helpforce play a critical and important role in the project, they support programme management, stakeholder engagement and service design, but even more crucially they are helping to measure and evidence the benefits that volunteers can bring with their help they have been able to model an estimate that this project will impact positively on approx. 10,000 patients in year one and approx. 24,000 patients in year two.
	• These are not just patients within the hospital but are those on waiting lists, attending telephone appointments and people recovering and living well at home.
	• There are a range of volunteering opportunities to support patients along every step of the patient pathway on waiting lists, being treated on site, post discharge and living well with some being embedded and some being within its initial stages and some being scoped, these being;
	    o Waiting well – this is volunteers making an initial comfort call to patients on waiting lists, do they still need their appointment, or can we give it to someone else, do they need help accessing the video consultation? Do they need interoperating or sign language support?
	    o These questions help to ensure patients are ready and they get the best out of their appointment with the aim of reducing those DNAs, cancellations and increasing flow

	o Working together with the voluntary sector to provide more intensive support to patients to help them shape up for surgery with the aim of reducing length of stay, increasing flow and connecting people with local support. o Accessibility – These are volunteers supporting patients to access their telephone and video consultations, this role was developed at the royal free where is reduced DNAs by 15%. o Building on the already successful hospital responder model getting, frontline staff to identify even more tasks that Volunteers can do or be trained to so that it frees up their time for clinical work. o Volunteers calling patients that have already been discharged and identifying those at risk of deterioration and connecting them with community support with the aim of reducing readmissions and increasing safety. o Engagement work – to help make Volunteers workforce more diverse because it's really important that these roles are carried out by volunteers from different cultures and backgrounds so that they can help people from those communities to access services. o Data is crucial so they are currently gathering and analysing waiting lists, DNA, length of stay and comparing that with joint strategic needs assessment deprivation data to help really understand the different demands that are put on the system by different communities and where health inequalities are. • Where are we now? o Last month the business case was approved at GEH Board which means they are now able to roll out phase one. o They are focussing on the hospital component so developing responders and looking at developing the calls on waiting lists and are hoping and planning to increase the number of calls to people when they have been discharged. o They are rolling out the community elements in North Arden and Nuneaton South and the business case released George Eliot Clinical Staff and data analyst's time. o It's also increased Helpforce's support in terms of understanding the impact of the project and spreading the learning. o There are two Community Meetings scheduled for 13th June and 4th July in North Arden and Nuneaton South. • The key purpose of the Community meetings is to bring a group of different stakeholders together so statutory providers, local people, people representing local community organisations to answer two questions, these being; o What are the interesting roles for Volunteers to help address the demands of that Community places on the system o How can someone do that in a way that is taking a deeply asset-based approach and build on the capabilities that already exist in that Community rather than coming into the Community with some pre-set ideas which can often marginalise so ignore the existing capabilities within that community. • In terms of demands, there are three areas that more information is being gathered on, these being; o What are the calls that are going on in George Eliot Hospital telling us about additional demand that might be in the community so they may be phoning people that are on waiting lists for an appointment and they find that they have got some transport needs or they are concerned about what happens to their pet when they come into hospital or concerns about post discharge etc. so the plan is to have a thorough pathway into Community organisations that have funding support to carry out that activity o Using a demand basis and understanding more precisely what the demands are that the patients listed with the GP practices in that PCN are placing on the system.

	• What are the capabilities in the community is a key question.
	• Timeline – They are currently building on the processes to collect the data required to evidence a positive impact at the start of next year if they are to secure funding for year two.
	• The ask of partners is;
	    o Are they happy with the plans?
	    o Are partners happy to help with the team have any questions or come up against any challenges?
	    o Provide advise on how they can approach WN Place on funding support to help expand and grow the project across more PCNS
	
	Questions/Comments
	
	JC felt that this was interesting and would like to work with the team in terms of their resources, whether they are internal or at Warwickshire County Council or services they commission to help with Volunteering etc.
	
	JC referred to a section of the presentation on the use of volunteers to reduce health inequalities and asked what was meant by that to which BM responded that there are a lot of this project that are at different stages, and this is one of the areas that is being scoped currently. Conversations have taken place with the Royal Free and they've explained the detail of the role and it's something that they wanted to bring into GEH as they wanted to test it and try it but they believe that the role works really ell and has had a positive impact on their DNA rates.
	
	JN felt there was a connection to be made within Digital and Community Capacity to which JC confirmed she would link with BM outside of the meeting to make these connections.
	
	JN asked partners to think about opportunities and contributions that could be made as a Place there is a £25-£30k contribution factored in from Place so would like to connect with the Health and Wellbeing partnership in relation to funds that JN is aware is available and asked partners to think about where they think there may be some available funds that could be used.
	
	EJ felt there were some echoes in this project with the Population Health Management projects that have been done before so wanted to highlight there is some existing data that could benefit this that has already been collected for this type of purpose but going forward making some links with the healthy intent for future projects might be a good idea.

6.	**<u>Quality at Place – RY</u>** CW Quality Strategy Phase 2 V 2.7 Final.pd RY shared the attached presentation in relation to the quality strategy with partners, the main points being; • The strategy has been developed over a number of months being co-produced with all of the SQG members which covers the majority of organisations and providers recommended by NQB. • There is some representation missing on that group which the chair is currently trying to resolve, one of those representatives in the Primary Care Network and Primary Care as well as Place.

	- There has been guidance published over the last year and a half which has been iteratively used as it's been published to shape the what the strategy looks like and what the national team are saying should be delivered. - The hope is by working together with system quality partners is that they will improve outcomes and experience and value for money for the service for patients. - The hope is that it will help improve outcomes, effectiveness and reduce inequalities. - They have worked over the last few months to ensure they have identified the quality challenges listed within the presentation which are; - Culture, engagement and system working - Workforce - Covid Physiological and Psychological - Patient Flow/UEC - Population and Individual Experience - The challenges are very similar to other systems and have been tested out with all of the quality partners at the SQG and have been tested out at the shadowed ICB Board so the hope is that they would be representative to Place with the question being, do they resonate at Place level and how do they make sure that the Place challenges are being represented also. - RY then talked through the next two slides which is based on the long-term plan with them being the current system transformation programmes that are being working on across Coventry and Warwickshire, these being; - Electives - Cancer - Diagnostics - Integrated Pharmacy and Medicines Optimisation (IPMO) - Maternity and Neonatal - Urgent care - Procurement and Back Office - Income Generation - Children and Young People - CYP Mental Health - CRY Physical Health - Autism and written statement of action - Mental Health and LDA - Estates - Digital - The next slide showed where the quality improvement should be driven from, they shouldn't be driven from top down but should be from the bottom up from where the work is actually happening. - It represents the providers, primary care networks, voluntary sector, everyone that is working together to deliver patient care and then that is bought together at a place level. - Place would then be driving up anything they can't fix or respond to directly at a place level or if they think it's a wider system piece of work, they would then be escalating it to the system quality group. - RY asked partners to take note of that specific slide and consider if they do think it is representative of how they see the system developing. - The next slide represents the Governance with the red statements representing that some of it can't yet be bottomed out until the ICB is a statutory function and all of the places are set up because their input is needed to understand how the operating model should look like and so might change after the ICB designation. - RY moved onto the Quality Reporting at Place slide explaining that there is the current CCG quality assurance and reporting in place and that will remain in place until the new approach is decided.

	• There is new guidance that is coming out around this about what the escalation process should look like and until the delegated functions are and what will be delegated to the ICB and the consequence to place then it is difficult to fully what the assurance mechanism will look like so once again, this may change but are currently referenced as a guide of what it will look like. RY asked partners for their questions and asked them to think about how they may get a response from partners as a group within a committee. RY asked for partners views on; • Whether this strategy and the principles to deliver quality are represented and whether partners support them • They would like to understand if partners support the principles for delivery on the benefits of a system wide Quality Strategy in Coventry and Warwickshire (slide 6) • Do partners recognise and agree with some of the quality challenges, there may be others that partners feel is not represented that need to be included • Partners were asked to review the Governance Structure (slide 12) who is representing place and organisations at the various committees as partners may want to review and change this • Partners were also asked to think about how Place can support the delivery of the strategy, do partners see place aligned with it or does Place have its own strategy and how would that work • Partners were asked to review the engagement slide and provide feedback on if they feel anyone is missing in their view and if so, who else should they be engaging with **Comments/Questions** TS felt that the presentation was well received and her question was around stakeholder engagement and who is representing SWFT as she is really keen that a representative is around the table. TS also agreed with JN's comment in the chat box in relation to being an early adopter in this. RY informed TS that SWFT are represented on the SQC by the Director of Nursing, and that person has been asked to liaise directly with SWFT to get their feedback on the Strategy. TS informed RY that Fiona (the current Director of Nursing) is temporarily out of the office at the moment and would take responsibility in ensuring that SWFT are fully represented. RY offered support in terms of representing the strategy to colleagues at SWFT. JN felt there was an opportunity to go back and check that partners organisations are engaged and how. JN felt that in terms of Place this particular meeting is focussing on integration and felt that the group should look at quality in the context of the patients journey through a range of organisations as opposed to the way it has been tended to look at previously as an organisational and quality assurance function. JN felt piloting an approach around this and looking at the quality of the patient journey and what impacts on the quality of outcomes that the individual has as a consequence of that journey. JN felt that the natural fit for this would be under the quality work strand within the Place Readiness programme and pick up conversation in relation to this under that workstream.

	JN thought it might also be useful to think about the dashboard and what matrices sit within the dashboard that may be indicative of quality at place across that patient journey that could then be used to support a different sort of conversation around integration handoffs, journey time, accessible outcomes and patient experience through the place offer in terms of health and social care. JN offered to co-ordinate partners responses in relation to the questions and formulate a place response from those responses. **ACTION – Questions to be circulated to partners and ask for responses and then be collated into a place response. JN/SY** **ACTION - Position quality under the Place Readiness Workstream as outlined above and then link into conversation around the dashboard development. SM** **ACTION – Partners to review stakeholder representation and identify who is their representation and go back to RY with any queries or amendments to that representation. ALL** **ACTION – This is to be put as an agenda item at the Primary Care Development Group for discussion. AK/EJ**

7.	**Population Health Management – SM/RC/TH**
	
	Enc 4 - Place Exec 09.06.22 - PHM V1.dc Enc 4.1 - PHM Presentation 060622.
	
	SM introduced this item which has been a 6-month programme which partners have been a part of.
	
	Learning sets 5 and 6 have not been able to go ahead but work has been on-going in the background from the task and finish group who are in attendance at today's meeting and will be talking through the outcomes of the work to date.
	
	The purpose of this item is to feedback to partners what would have been discussed as part of learning set 5 and 6.
	
	SM handed over to TM to talk partners through the attached presentation, with the main points being;
	• TH talked through the Place on a page slide which outlines the different ALS sessions and the purpose of each of those sessions.
	• Cohort selection – the selected cohort is made up of 920 individuals
	• Place priorities and principles;
	    o Priority area obesity / pre-diabetes
	    o Preventative agenda
	    o Best value – finance / patient outcomes / patient experience
	    o Health inequalities- particularly deprivation
	    o Embrace a wide range of assets / partners
	    o Likelihood of engagement / impact in short-medium term
	    o Inclusion of CYP
	• The selection criteria is as follows;
	    o Obese, but not diabetic… pre-diabetes obesity principle

	- Deprivation High / Middle…tackling health inequalities - Complexity Low…focus on prevention - History of smoking…prevention, health inequalities, engagement with wider partners - Age 20-59…not directly including children, but indirectly through parents – potential for lifestyle / family intervention • The desired outcomes are; - Short Term: ▪ Increased uptake in smoking cessation services ▪ Increased uptake in number of fitter future referrals - Medium Term: ▪ Reduction in smoking ▪ Continued increased uptake in smoking cessation. ▪ Improved BMI rates ▪ Continued increased uptake in fitter futures services. - Long Term: ▪ Reduction in clinical interventions ▪ Reduction in sick note days for chronic illness ▪ Sustainability • SA talked through the interventions that were outlined on the Cohort Contracting Approach slide which would effect change for the 920 individuals. • When looking at the cohort of patients they are going to be living in deprived areas, obese etc. and they wanted to try and make them be more engaged within the programme and wanted to identify the cohorts through the means that they would engage with, for example targeted Facebook adverts, put information on community notice boards to try and get them more aware of the population health programme and how it can help them. • Each individual would be given a pre programme questionnaire which will ask questions about their lifestyle and their health to gauge what their mindset is and then discuss with them the introduction of fitter futures and if they are aware of this and if they have considered things like smoking cessation. • It isn't thought that people would engage with this straight away so a period of three months would be given to enable individuals to think about it before engaging with the services. • After the three month period has come to and end then the individuals would be contacted to see if they have engaged with the services. • In the medium term those that have engaged and have had some sort of positive effect would receive a phone call to check in with them every two weeks. • After 12 months the individuals will then be reviewed to see the progress. • The long term would be after 12 – 18 months look at the cohorts to see if they are exercising more, eating healthy, have they stopped smoking etc. and then use this model to role it out more wildly and invite this cohort to speak to future cohorts. • TM talked through the Finance and Activity Modelling which outlines the possible savings and reduction in appointments. • Lessons learned; - From a people perspective ▪ It takes time to embed new ways of working. Repetition and strong leadership is key in order to focus on what needs to be done ▪ Early conversation needed with patient group and ongoing engagement throughout the programme - From a skills and knowledge perspective ▪ Input from Finance, GP lead, Business Intelligence (BI) and Programme Management has been invaluable ▪ Access to BI is needed to accelerate local implementation of PHM

	- From a ways of working perspective - Importance of system buy in and Place partners driving the work forward - Additional meetings requires outside of Task and Finish Group and Action Learning Sets – ensuring right people involved to allow for learning, embedding new PHM approach and behavioural change - RC then talked through the Place case study which outlined the learning which is one of the key outputs of the programme in terms of the learning. - They visualised the output that they need to put together at the end of the programme which summarised the programme and intervention. - Next steps; 6-12 months pilot with pump priming funding - using the cohort identified - Develop service specifications and pathway - mapping with input from clinical leads - Consider IG needs for data sharing - Develop performance and outcomes - dashboards with patient and stakeholder - engagement - Shifting resources without adjusting block - contract finance values - Proactive and visible leadership - To sustain the work going forward, all relevant - parties to be involved: - Public Health - Primary Care Network - Population Health Management Board - Current contracting model - Acute Services - Block contract payment underpinned by PbR, activity national tariffs and local prices - GP Appointments - Mental Health Services – Block contract - payment - Public Health Services - Contracting principles - New models of care through collaborative - working enabling shifts in activity and costs - between providers - Mechanisms to move money around the - system must be aligned to financial frameworks - agreed across the ICS - The questions for this group were; - Do partners support the intervention and want to take this forward If they think about what this means across the place, the contribution of Place if an investment is needed. - The PHM approach aligns to the Place Readiness programme and there is a work stream as part of that and feel the approach and principles and tools would sit neatly within this and supported by business intelligence and the wider WN intelligence cell and any interventions that are developed in line with this partners would need to consider how they are aligned with the existing place programme that cuts across those themed areas that are reported on as part of place reporting with this with the recommendation being that it sits within long-term conditions.

	Questions/Comments
	
	SMy didn't feel at this point he could assist with the questions other than he is entirely happy to trust the people that have been working on this and that it seems logical. SMY is happy for this to proceed.
	
	SMy was enthused when this programme first came to the area but then due to the huge amount of time that was required he wasn't able to get involved in the level of detail that was needed and suggested the need for an away day to go through the programme and ask the questions and get up to date.
	
	JN summarised the conversations as;
	• In terms of the approach and embedding this into the programme of work it seems sensible in the way that has been described
	• In terms of the specific cohorts of patients in terms of the smoking and obesity etc. we have made a number of suggested links to opportunities that could enhance the intervention that has been scoped and developed as part of the task and finish group.
	• There are further opportunities to explore outside of the meeting with specific colleagues that have access to other resources or services for that might be appropriate for that client group to wrap around and link into that intervention and it is a likely that a bit more focussed conversation is needed with those individuals to explore what those contributions might be in terms of the services they lead.
	• There were a number of suggestions in the chat box for those specific cohorts, these being;
	  ○ JC conscious of the cost of fresh produce just now, and wondering what sort of consideration has been given to food poverty issues
	  ○ Some ideas for connecting: Tabaco control group - have we linked into this group and the initiative's they are supporting? Can we link this is to the Health Passport discussion - can we invite Sara to the planned meeting - this might help with the intervention and link in the GRO app as part of this - Think good opportunity to link in to HWB Partnership initiatives under the JSNA we have identified, can we link with PCN's re dieticians for the ARRS roles
	  ○ JN Could we connect with healthy schools programme to link in to family element
	  ○ JC Food banks themselves are struggling with donations, and many don't offer fresh produce at all (I know Edible Links does). Access to affordable healthy food feels like a potential barrier to personal health improvement efforts, and one that as a system we might want to think about

8.	**Healthier Futures – JN** Enc 3 - Healthier Futures - Warwickshir Due to time constraints the report was taken as read.
9.	**WN Community Diagnostics Centre – JN** This item was deferred to the next meeting due to time constraints, SM added the following into the chat box for partners to consider ahead of the next meeting;

	SM wanted to make Place Executive aware they are submitting the Phase 2 business case tomorrow to the Regional and National team as per Catherine Frees verbal update at the last meeting. On the 26th May, SM attended Primary care development group to signal that we will need to meet and review clinical pathway redesign opportunities. We are navigating some of the system discussions that have been taking place and will be in touch to inform about what groups/when and who for representation from our partners please.
10.	**Care Collaborate Update - All** This item was deferred to the next meeting due to time constraints.
11.	**AOB** There was no other business.
	Date of Next Meeting: Thursday 7th July 2022 09:00 -11:00 Microsoft Teams Meeting – diary invite