Bradford Teaching Hospitals
NHS Foundation Trust

PARTNERSHIPS COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date:	Tuesday, 23 July 2019	**Time:**	14:00-16:00
Venue:	Trust Meeting Room, Trust HQ, BRI	**Chair:**	Max Mclean, Chair
Present:	Non-Executive Directors: - Max Mclean, Chair (MM) - Amjad Pervez, Non-Executive Director (AP) Executive Directors:- - John Holden, Chief Executive (JH) - Bryan Gill, Chief Medical Officer (BG) - Matthew Horner, Director of Finance (MH)		
In Attendance:	- Edward Cornick, Head of Policy (EC) - Alison Smith, Head of Partnerships (AS) - Paul Shercliff, Policy Manager (PS) - Jacqui Maurice, Head of Corporate Governance (JM)		
Observers:			

No.	Agenda Item	Action
P.7.19.1	**Apologies for Absence**	
	It was noted that Laura Stroud was not present and had sent apologies.	
P.7.19.2	**Declarations of Interest**	
	Declarations of interest were asked for by the chair and none were received.	
P.7.19.3	**Minutes and actions of the meeting held in 17 May 2019**	
	JM confirmed that the meeting was quorate. JH stated that there were a couple of minor changes to the minutes that he would address offline. The minutes were approved. AS provided an update on an action concerning how Bevan House linked with Community Partnerships. She stated that Bevan House is a part of Community Partnership five. It was confirmed that the Airedale action, regarding links with other committees would be addressed during the meeting. It was confirmed that all actions from the last meeting could be closed. JM provided an update regarding the Partnership Committee Annual Report to the board, JM stated that Tanya Claridge and MM had agreed that the report will be deferred to August, primarily due to the changes to the Terms of Reference.	
P.7.19.4.1	**Matters arising from the Board of Directors**	
	MM asked whether there were any matters arising from the Board of Directors. There were none.	
P.7.19.5	**Strategic Risks relevant to the Committee**	
	MM queried this item and how it should be addressed. JH stated that on review of the minutes from the last meeting, it was clear that the committee reviewed the strategic risks at this point in the agenda and later on the meeting. He queried how we best use this part of the agenda to add value.	

	EC noted that this process had been introduced recently. MM stated that he would plan to pause at the end of the meeting to see if there is anything to add to the substantive discussion. MM queried which of the risks had a high residual risk level. EC confirmed this was risk 3091, and that due to the complexity of the decisions made in the system that it is hard for the Trust to influence, the residual risk level is 8. MM thanked EC for clarifying this point. MM queried what the specialty on a page work referred to in the update was for this item. EC responded by stating that this was driven by WYAAT looking at how different specialties are organised across secondary care in WY&H. MM queried how this would link to the collaboration with Airedale. EC confirmed that it would link, but that it is a bit of a grey area. JH echoed the points EC had made and stated that we need a way of determining whether specific specialties are areas the Trust wants to expand in or not. BG stated that WYAAT has agreed that there will be networks in services, with some being more formal than others. AP queried whether we would be continuing to follow the clinical strategy or whether that will need to change, depending on the outcome of this work and queried whether this is a risk. BG clarified that he viewed that as a potential opportunity but that would need to be a discussion about what we try and do more of and what we accept we may need to do less of. BG stated that this was where engagement with clinical directors and CBUs would be important, with a focus on areas of strength. MM queried where these discussions would take place. BG confirmed that exec time outs and the CBU cabinet meetings would be a good place to start, and following this it is likely to go through the different WYAAT forums. BG raised vascular as an example and how this demonstrates that it takes time to progress work like this, given the programme started three years ago. MM queried whether CBUs would help with this work. BG confirmed they would and JH stated that working with Airedale might enable the Trust to respond more quickly, than work through WYAAT.	
P.7.19.6	**Vertical Integration update**	
	MM asked JH to introduce, and AS spoke through her slides on the item. AS updated the committee on the nature of the risks and talked through the mitigations that are being followed, including the Trust signing the Strategic Partnering Agreement and participating in a review of happy, healthy at home, the local system strategy. AS provided the committee with an update on the Primary Care Networks and Community Partnerships, and that there would be opportunities for the Trust to engage with both. AS noted that a five year pot of funding, aiming to reduce inequalities in Bradford was available to cover the part of the city covered by Bradford City CCG, she noted that BTHFT had not been engaged in this as much as would have been ideal. AP queried what the benefit to the Trust was of engaging with partners through the SPA. JH noted that it gives the Trust a lever that it did not have before and MH stated that it made it possible for the Trust to be a part of a sustainable local system. AP queried whether the Trust was the major influencer in the partnership. AS, in response, stated that the way the partnership worked was that the two	

	health and care partnership boards make decisions relating to how money is spent, with those decisions then ratified by individual boards. MH noted that a cross-system finance and performance committee had been set up. AP queried how plans for system wide data were progressing. JH noted that there was a need for common data across the system, incorporating getting a shared version of the truth between partners on finance and quality. AS noted that a common dashboard had been looked at, and was being developed by the CCGs. AP stated that one of the reasons for raising data was the need to look at 'big data' across the patch. JH noted that something on this could be brought back to the committee on population health and joining up data. MM queried whether it was in the interests of the Trust to reduce the number of people coming through the door, now that a fixed income agreement had been signed up to by the Trust. MH confirmed that this was the case. MM stated that if that is the case then investing in services nearer to people's homes is in our interest. JH stated that if what the system achieves is shifting demand from hospital to community – how can income move away from the acute to the community and queried whether this would result in financial pressure on the Trust. MM queried where discussions are taking place and MH stated they were taking place in breast and general surgery, where there had been a significant increase in demand. BG stated that there had to be a crisis for something to happen differently when it came to dermatology, which is a positive example of activity being moved from the hospital to the community, he stated that Primary Care Networks would have a role in this. MM queried how the relationship between PCN clinical directors and BTHFT was being managed. AS updated the group on Richard Haddad's thinking about bringing all of the clinical directors together and the group had a discussion about how they could be engaged with the Trust's clinical directors. AP queried how this work would help to make a patients journey through a pathway more connected. AS stated that she thought community partnerships will be a way for this to happen and JH stated that GP is still the ultimate care navigator for patients. ACTION: MM asked whether a paper could be brought to the next partnership committee about what our intention is regarding how PCNs and our CBUs will link. It was confirmed this would come to the next meeting and that the action would be held for JH. ACTION: It was also confirmed that a future item on data would come back to the meeting and that this was also for JH to arrange. MM closed the discussion, and thanked AS.	JH JH
P.7.19.7	**Airedale Collaboration update**	
	EC spoke through the item and explained that his presentation was split into two parts – one on how we provide assurance to other committees on the collaboration with Airedale, and then a general update on mitigation against the risk.	

	EC talked through the two risks, one around understanding the interdependencies the Trust has with Airedale and other around strategic alignment between the two Trusts. EC updated the committee that at the moment there was a good strategic fit between the two organisations. AP queried what was meant by a lack of understanding regarding clinical interactions. In response, BG stated that there were two parts to this – interfaces that happen on a professional level and then formal arrangements between the two Trusts. BG stated that the Trust is just beginning to understand where the pressures are in Airedale's services. BG stated that having better access to patient records between the two Trusts would be an example of something that could be improved. EC spoke through the mitigation that was in place in relation to the two risks – including the clinical leadership that has been put in place, both at a programme level and in individual specialties. EC noted that a high level strategy, looking to describe what the programme will deliver is planned. EC stated that a grey area for the programme was what should be considered as an operational issue the Trust needs to fix and how that fits in to the wider strategic piece of work that is needed. EC asked whether there were any questions. EC then spoke through how the different committees assess the risks associated with the programme and spoke through the potential options. MM queried what AFT's approach was, EC stated that he was not sure but that this is a question for directors of governance from both organisations. MM asked for views. In response BG stated that it needs to be clear where the detailed sign off of changes to services agreed through the collaboration takes place. EC, responding to BG, stated that this is a role for the joint governance structure – e.g. the programme board. JH stated that some of this is not that clear and that once the programme develops it will raise questions about workforce, finance and quality that will need to be considered by those other committees. JH supported the hybrid option outlined by EC. BG stated that he thought there was a gap around where we have our own internal conversation about the Airedale collaboration to assess some of these areas. MM queried whether the committee accepted there was a gap/need for this. EC accepted there was a gap and that this would need to be addressed. ACTION: MM confirmed that a proposal for internal due governance for potential changes in service delivery that arise from the programme would come back to the next committee. MM queried whether other committees would receive a high level report on the progress of the programme. BG stated he did not think this was necessary and EC agreed that it could go on a case by case basis and that this should be raised with other committees. MM queried where an assessment of whether the programme was aligning to the clinical strategy. ACTION: The committee agreed that it should actively identify risks that need consideration to other committees and it was agreed that an overview of what we have raised to other committees some come back to this committee.	JH JH
P.7.19.8	**Horizontal Integration update**	
	MM asked JH and EC to introduce the item. EC spoke through the risks	

	associated with the item, starting with risk 3091, explaining why the score was high and why there was a high residual risk. EC spoke through the mitigations in place, including the specialty on a page piece of work, which was referred to earlier under item P.7.19.5. EC explained what the five year strategy being created at a WY&H level was, and explained that he was on the editorial group for this strategy. AP queried whether the Trust had to engage in this work. EC stated that there were some decisions that were made that would be hard to move away from e.g. WYAAT. JH stated that technically you could pull out but it would be damaging to relationships Trust is trying to build. EC stated that the example of vascular demonstrated that it was possible to make decisions, although he noted that CHFT were not initially content with it. AP queried whether the Trust has adequate influence. In response JH stated that the Trust is one of the six in WY&H, and that Leeds has a lot of influence. He stated that the more the Trust does to build alliances, the more influence the Trust will have. EC spoke through risk 3395 regarding vascular, stating the longer the Trust is non-compliant with the service specification, the greater the risk that the decision is unpicked. EC spoke through the mitigation and the issues that are ongoing regarding interventional radiology, and the lack of consultant cover at CHFT, where there is only one locum consultant who is away for August. A plan is being developed to cover August. BG stated that there is still a need to go out to public consultation on the decision around having two arterial centres in WY&H. He noted that he did not expect material objections from the public consultation. BG stated that there is still a long way to go to deliver this model. MM agreed. BG stated that the Trust does have oversight of the work to make progress towards the model, and stated that he takes over as chair of the WY Vascular Board next week. MM closed the item.	
P.7.19.9	**Partnership Committee Dashboard**	
	MM asked whether there was anything in particular that should be raised in relation to the dashboard. EC stated that it was important to note there are now four items, as Airedale collaboration has been added as its own areas. JH stated that it was important to note the RAG rating and to reflect on whether it was consistent with the discussions that had been had at the meeting. JH stated that the committee had less numerical KPIs rather than other areas, but that it should be possible to develop something like this for the Airedale collaboration. MM thanked JH for the update and queried what the timescale for the collaboration was. EC confirmed this was 18 months-2 years. MM confirmed that the dashboard was agreed.	
P.7.19.10	**Internal audit operational plan 2019/20**	
	JM stated that it was important for the committee to be aware of what is in the internal audit operational plan, stating that the plan had been to other committees and to the execs. JH stated that internal auditors have some time to address this – 8 days in quarter three in the plan. JH stated that this could be done system wide and stated that this is what internal audit were planning to do. There are eight days in quarter four which could look at the acute collaboration. It was confirmed that the committee were content with this.	
P.7.19.11	**Partnership Committee Terms of Reference - Review**	
	JM stated that the committee's Terms of Reference were reviewed by board and the audit and assurance committee, and approved in January. JM stated	

	that all of the work programmes for the committees have an action to bring them back in six months to check whether they are working. BG stated that his title in the Terms of Reference should be amended to Chief Medical Officer. JM noted this. JH stated that under sections 8.1 and 8.2 regarding the agenda and papers, it talks about agenda setting etc. JH and MM agreed that in practice this is not how it has worked and JH acknowledged that the chair could have a greater role in the agenda setting. MM queried who is nominated deputy for the committee was, asking whether it was LS. This was confirmed and MM asked whether the committee was content to note the Terms of Reference and this was agreed.	
P.7.19.12	**Board Assurance Framework**	
	JH spoke about strategic objective five which is about collaborating effectively with local and regional partners, the assurance level for the last quarter was green. JH confirmed that in his view the assurances the committee had received were sufficient. MM agreed and so did the committee. JH spoke about the risk appetite for this area being 'seek' and that there was no suggestion this should change. MM agreed and it was confirmed that the committee approved the risk appetite level and the green assurance level.	
P.7.19.13	**Any Other Business**	
	None.	
P.7.19.14	**Matters to share with other committees**	
	MM noted that there were a couple of actions around governance to share with other committees. MM queried what the best way to progress this would and queried whether it should go to board. In response JH stated that his suggestion would be to engage other committees by starting the process. MM confirmed he was happy with that and EC agreed to bring an articulation of this to the next meeting.	
P.7.19.15	**Matters to Escalate to the Strategic Risk Register**	
	None.	
P.7.19.16	**Matters to Escalate to the Board of Directors**	
	None.	
P.7.19.17	**Items for Corporate Communications**	
	None. The meeting was closed by MM.	
P.7.19.18	**Date and time of next meeting**	
	24 September 2019 2-4pm, Trust HQ meeting room.	

Actions from the Partnerships Committee held 23 July 2019

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
23/7/2019	**P.7.19.6**	An item on the Trust's plans regarding how it intends to link to Primary Care Networks and Community Partnerships to be brought to a future meeting	Director of Strategy & Integration	24/09/2019	covered under the vertical integration and Airedale collaboration items on September agenda – action closed
23/7/2019	**P.7.19.6**	An item on data and population health management to come to a future meeting	Director of Strategy & Integration	TBC	Not for September's meeting
23/7/2019	**P.7.19.7**	A proposal for due governance for potential changes in service delivery that arise from the programme would come back to the next committee	Director of Strategy & Integration	24/09/2019	covered under the vertical integration and Airedale collaboration items on September agenda – action closed
23/7/2019	**P.7.19.7**	An overview of what Partnerships Committee has raised to other committees to be brought to a future committee meeting	Director of Strategy & Integration	TBC	