TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting via MS Teams. **Date:** Wednesday 2nd March 2022, 09:30-13:00

Voting Members:

Sir D Nicholson (Chair)	(DN)
Mrs L Writtle Non-Executive Director	(LW)
Mr R Beeken, Chief Executive	(RBe)
Dr D Carruthers, Medical Director	(DC)
Prof K Thomas, Non-Executive Director	(KT)
Mrs R Hardy, Non-Executive Director	(RH)
Ms D McLannahan, Chief Finance Officer	(DMc)
Mr L Kennedy, Chief Operating Officer	(LK)
Ms M Roberts, Chief Nurse	(MR)
Mr M Laverty, Non-Executive Director	(ML)
Ms F Mahmood, Chief People Officer	(FM)

Non-Voting Members:

Mr D Fradgley, Director of Integration (Interim)	(DF)
Ms K Dhami, Director of Governance	(KD)
Dr M Hallissey, Assoc. Non-Executive Director	(MHa)
Mrs J Wass, Assoc. Non-Executive Director	(JW)
Ms V Taylor, Assoc. Non-Executive Director	(VT)
Mr D Baker, Director of Partnerships & Innovation	(DB)

In Attendance:

Mrs R Wilkin, Director of Communications	(RW)
Ms H Hurst, Director of Midwifery.	(HR)
Mr D Conway, Assoc. Director of Corporate Governance.	(DCo)

Guests:

Ms L Wood, Sandwell Mortuary Services (LWo)

Minutes	Reference
1. Welcome, Apologies and Declarations of Interest	**Verbal**
Chair DN welcomed Board Members to the meeting. **Apologies:** There were no apologies or declarations of interest.	
2. Staff/Patient Story	**Verbal**
MR welcomed the Mortuary Services team representatives to the meeting. LWo presented information on a Quality Improvement Initiative put in place that sees the Mortuary operate as a virtual ward to ensure dignity and respect of deceased patients remains throughout their care to address previous patient family and funeral director complaints around the Trust's handling of deceased patients. Complaints centred around: o Lines remaining in situ in deceased patients. o Loss of belongings and jewellery. o Inconsistent handover, review and special instructions being conveyed when presenting deceased patients to funeral directors.	

LWo advised that a Mortuary Patient Passport has been introduced to provide documented communication between families, the Trust and funeral directors around deceased patients.

It was advised that further to the Mortuary Patient Passport, the Mortuary team has created a more transparent process around dealing with deceased patients to ensure nurses are better knowledgeable of the process and therefore well-equipped to provide consistent communication on the process with families of deceased patients.

The Chair thanked LWo for her presentation and reflected on the importance of viewing a deceased patient as a patient and extending the duty of care to them as such.

LW queried whether family feedback had been provided post the changes being implemented. LWo advised that there has been an increase in family gratitude at the end of the journey, with thank you cards highlighting the value families place on the more individualised approach the Trust is taking.

FM asked LWo whether she had any suggestions for improvement opportunities relating to better communication between the ward staff and Mortuary staff to help educate staff about the importance of the continuation of compassion and dignity of the deceased patient, as well as smooth transfer of information to Mortuary staff. LWo confirmed communication at present is very positive and that the biggest issue relates to accurate completion of the Notice of Death to ensure it covers the principles of three identifiers. Ward staff having better understanding of the reason behind the Notice of Death, through further training and development opportunities, would be beneficial.

FM confirmed the development of a large programme of accreditation to clinical excellence is in train which will encompass the elements discussed and advised LWo's involvement in this programme would be beneficial. FM offered to work with LWo on reviewing existing training in the interim.

Discussion was had around LWo's involvement with the End of Life Six Promises project as well as her experience of different requirements across multifaith groups. LWo confirmed she is not engaged with the End of Life Six Promises project but is open to her involvement. DF confirmed they will follow up with Anna Locksley to make this connection.

LWo advised the Trust is very good from a multifaith perspective and work very closely with the local community in this regard. It was advised that the Trust offers a rapid release policy where patients can be released to funeral directors as soon as a medical cause of death has been issued. Positive feedback has been received from the Birmingham Muslim Burial Committee on this.

RBe queried how the introduction of the Mortuary Patient Passport was received by staff. LWo advised Mortuary has regular monthly meetings to open up new processes to consultation prior to implementation.

The Chair commended LWo for taking the initiative to undertake this task and the humanity she has displayed. He asked that all non-executives make arrangements to connect with LWo and the Mortuary team over the next year.

Action: FM to involve LWo in accreditation programme and on reviewing existing training.

Action: DF to follow up with Anna Lock to involve LWo in the End of Life Six Promises.

Action: All non-executives to make arrangements to go and see LWo in Mortuary over the next year.

3. Minutes of the previous meeting, action log and attendance	**TB (03/22) 001** **TB (03/22) 002**

	TB (03/22) 003
The minutes of the meeting held on 2nd February 2022 were reviewed and **APPROVED**. The action log was reviewed. It was noted that actions had either been completed or were not yet due.	
4. Chair's opening comments	**Verbal**
DN noted world events relating to Ukraine. He commented on Integrated Care System initiatives to bring together people in the Black Country Health Care System to see how the Trust can help and support the events, through medical supplies, volunteers or supporting Ukrainian staff.	
5. Chief Executive's Report	**TB (03/22) 004**
RBe referred Board members to the report and in particular the current status of the draft constitution (placed in the Trust Board's reading room) which provides for collaboration in the Black Country, taking a clear view about who should represent the acute/community sector on the Integrated Care Board and how that is determined. He expressed his belief that the organisation does not work alone but as a collective of providers and sought the Board's opinion on how best to influence that provider collaborative. He further explained that the draft Constitution as it stands does not contain detail on membership and composition of subcommittees of the ICB and needs to be set. RBe shared his opinion that the early stages of the Integrated Care System was around a concept of collaboration and making commissioning and provision decisions together though language is now changing with the reintroduction of the word commissioner as separate from provider. He advised of his concern that the ICB does not become wholly dominated by the strategic commissioner and remains a collaborative space. Discussion was had around the report. DF advised his view that the description of the sub-committees on slide 25 of the Board Pack is wholly inadequate and that the description of an Integrated Care Partnership on the left-hand-side and the place based partnerships on the right-hand-side do not describe what the white papers talk about. He stressed that the Board have an opportunity to try and seek to change the format of the ICB or the sub-committees to avoid a commissioner/provider split occurring. LW provided comment on the autonomy and accountability of the ICB versus that of the Trust and wondered whether this will change as of July and sought clarity on what role the regional tier plays and where accountability for an NHS Trust Board stops and where wider accountability starts. RBe advised that he hopes secondary legislation due to come out will clarify this. DB commented on capacity limitations in driving more than one agenda across the Trust and advised alignment as a system is required. He advised that if a group structure is necessary he would be in favour of considering this. Further comment was given on the provider collaborative in terms of the make-up and whether the Dudley Integrated Health Care (DIHC) partnership should be included in the provider collaborative. RBe agreed the issue relating to DIHC needs further clarification and he will seek to provide this in the coming months. LK advised he believes it is good to see the inequality lead on the ICB and hopes this acts as more than just a token gesture. ML sought clarity over whether a heavier weighting towards commissioning was as a result of a national or local driver and whether BSOL would be operating under the same approach. RBe advised this was a	

national instruction that is not for NHS Trust Boards to approve but for them to note.

RBe advised that in relation to BSOL, Richard Kirby, the Chief Executive of Birmingham Community, is helping the BSOL system pull together. RBe advised he has sought comment on how accountable officer representation around the BSOL provider is to be handled and that he will report his findings back to the Board.

DN rounded off by advising the Board they have an opportunity to bring people together to achieve success. He reminded the board not to get bogged down in a complex accountability planning system that takes away from the innovation needed for system development.

Action: RBe to provide further information in the coming months on how DIHC as a statutory constituted organisation could provide a system wide role

Action: RBe to provide further information on how accountable officer representation around the BSOL provider is to be handled.

6. Questions from members of the public	**Verbal**

No questions were received from members of the public.

Our patients

7. Our Patients: Dashboard	**TB (03/22) 005**

The paper was taken as read.

Board Level Metrics

LW queried where the Trust is ranked in terms of CQC quality improvement. DB responded that eight of the metrics reference back to benchmarking capability and these are the ones the Trust should work on improving as they all link back to the hospital combined performance score which is a predictor of where the Trust is on CQC.

LK further advised that to get an indicator of the CQC rating, there are four quarters which nationally represent outstanding to inadequate and that it is a combined element of these four quarters that drive the Trust's CQC standing at any one time.

ML queried where to look in the Board Level Metrics to track and see the Trust's progress. DB advised that Page 9 of the Public View paper shows the fall in the hospital combined performance score and the relationship between the four domains. He further highlighted that the FPC chart shows that there is substantial movement in a lot of items.

MHa highlighted that some of the key metrics that the Trust that has performed poorly on, for example, antibiotics and sepsis, have not been included. It was felt that this should have been acknowledged to ensure it is given the attention it warrants.

DN advised that this may be just a question of presentation given there are general points around specific areas, such as antibiotics.

RBe confirmed that the Board made an informed decision to slim down Board trackable metrics and by default the following metrics are being focused on: the quality and care provided, the quality of staff

experience and the population health outcomes the Board seeks to influence. RBe confirmed that going forward a clearer connection will be made between Board level metrics, SPC charts and natural variation and where it is a statistically significant trend, an explanation will be provided.

DC reflected that there is the need to think about how items are repeated in the report that have been expressed previously, for example, last month the report stated work was undergoing with sepsis and the plan was for the improvement project through March.

Perfect Ward

KT queried that the report states a small number of areas have yet to commence the audit process and whether this was due to roll out or that these areas were difficult to get engaged. MR advised that this is in relation to roll out, mainly for paediatrics and some special services.

RBe asked whether MR and LK can rephrase "unfunded wards" in the report as it is outmoded in light of the Funded Winter Plan that this board has approved. MR agreed.

CQC Domain Caring

DN confirmed there was no further questions on these.

Action: DC to work on formulating how to repeat things in the report that have been expressed before, or refer back to them, if work is still ongoing.

8. Receive the update from the **Quality and Safety Committee** held on 23rd February 2022	**TB (03/22) 006**

KT provided update on the Quality and Safety Committee.

Gold update on COVID-19 position, including vaccinations

It was advised there had been improvements in 62-day cancer and two week wait waits, though staff sickness rates were slowing the rate of improvement. Reasonable assurance was provided on services returning to normal.

Maternity Dashboard and Neonatal Data Report

It was reported that the national target rate for caesarean sections have been removed. The Trust's elective section rate at 10.1% is low and merits further investigation. There are staffing concerns in neonatal and community midwifery which were discussed along with actions that can be taken to improve this. All Trusts were asked to provide assurance against seven actions and the SWBH scored the highest in the local maternity neonatal services area. Partial assurance was provided.

Board Level Metrics and IQPR exceptions

This was discussed and partial assurance was provided.

Monthly Mortality Dashboard

Both the HMSR and the SHMI are showing an improving trend, but are still high and merit further vigilance. Reasonable assurance was given. Thorough review of 90% of deaths showed none were preventable.

IT Outage Update

The findings of the Dudley Group's external review were presented. A suboptimal structure was found in a

number of roles which is going to take time to correct and so only partial assurance was provided.

Discussion was had around caesarean rates and the difficulties of working to targets in this area given the dangers that can arise. DN advised that a culture shift is taking place within the Trust to move away from targets.

9. Receive the update from the **Finance and Investment Committee** held on 25th February 2022	**TB (03/22) 007**

ML advised that the business case for the MMUH was not yet ready for circulation. He advised that the affordability of the MMUH was considered and the rostered proposal was agreed along with an energy contract extension also having been agreed.

RBe highlighted the need to be crystal clear about point 7, the difference between waiting lists and waiting times. Improvement in waiting times is being targeted in the more immediate horizon and that is reflected in the planning guidance for next year and beyond. It was noted that the total waiting lists across the NHS in England will take years to get back to pre-COVID levels, but wait times, particularly long waiters, are improving and it is that that needs to be tracked.

LK commented that there was no assurance on point 8 but confirmed there is an activity plan in 2022-2023, but due to significant vacancies and sickness factors within theatres to even to return to the Trust's 2019-2020 plan will require investment in insourcing.

DN confirmed that the Trust's gas supply does not originate from a Russian source.

10. Receive the update from the **MMUH Committee** held on 25th February 2022	**TB (03/22) 008**

DN confirmed this will be taken up in the private session later this afternoon.

11. COVID19: Overview	**TB (03/22) 009**

The paper was taken as read.

LK confirmed community infection rate has reduced significantly from last update, and highlighted three main points:

<u>Current Inpatients</u>

LK reported that fewer COVID patient numbers has allowed the Board to start a reset programme to realign wards back to pre-COVID and reset ED departments.

<u>IPC regulation changes</u>

LK reported the following fundamental changes:

- Moved from FFP3 masks to surgical face masks;
- COVID and non-COVID pathways;
- Visiting has recommenced as of today.

<u>Workforce cell</u>

LK confirmed vaccination for staff as a condition of employment 5.8% fully 90.96% partially.

Place Vaccination Programme

- The 12-15 year old programme at schools continues;
- The 5-11 year old clinically vulnerable programme has commenced.

LK confirmed that the Trust has received good recognition for the programme they are doing at Tipton.

FM reported the Health & Social Care Secretary's announcement yesterday that regulations making COVID-19 vaccination a condition of employment for health and social care staff will be revoked from Tuesday 15 March. The Trust position is to encourage staff to fully vaccinate. Currently 1020 members of staff are vaccinated, 652 fully and 368 having received a single dose.

It was advised that 38 staff gave a clear refusal to engage regarding vaccinations, this is being managed sensitively and a proposal will be taken forward to the Executive team for consideration. A focus has been maintained on sickness absence management to decentralise the management of that in order to provide the Board assurance that workforce capacities are improving. Sickness figures improved to 4%, average sickness level is just above that at 6.5% and the Trust are on track to achieve the targeted reduction to 6% by the end of the financial year.

JW queried whether it was still a requirement of employment that new starters are vaccinated. FM advised the latest government announcement suggested that because they are not revoking the legislation until 15 March, the Trust are not currently at liberty to change their position with existing recruitment. The Trust's policy is to continue to confirm vaccination status for all staff, including new applicants, and to continue this, making risk-based decisions about where people are working.

FM confirmed that the four individuals who were rescinded have been contacted to encourage them to reconsider working with the organisation, with a risk assessment having been done to support that. Work is underway to identify those who may have accelerated their decision to leave the Trust through retirement or other means as a result of compulsory vaccination, so that the Board can be provided with assurance that staff haven't been lost unnecessarily.

DN queried whether the number of COVID patients in the hospitals was down to 80? LK confirmed as at the time of the meeting the number stood at 66 and was decreasing steadily.

12. Finance report: Month 10	**TB (03/22) 010**

The paper was taken as read.

DMc highlighted the possibility of a small surplus for this financial year driven mainly by the underwritten costs of the Elective Recovery activity which hadn't been assumed in the plan for the second half of the financial year, a bigger risk reserve than the Trust started off with, which has to be moved out to the providers, and finally slippage against the £4.9m worth of Winter schemes that were provided for in the second half of the financial year.

It was confirmed following Month 10 performance the year end forecast reported is now a surplus of £5.129m. The ICS surplus is expected to be around £20m, and the Trust's share is £5m of that. From a capital programme point of view that's still performing well.

DMc stated the Trust has been grateful to receive five or six PDC awards quite often without the bidding process, these have funded brand new very useful equipment and the Trust is striving to spend those PDC before the end of the financial year, and not result in an underspend, to avoid losing that funding opportunity.

DMc confirmed cash balances remain strong at £54.5m at the end of January.

ML queried what is happening to the underlying deficit during the course of the year and whether there is any danger of penalties if delivering a large surplus. DMc advised the danger is there is a view that the system has got more money than it needs and that can make the future financial year and the messaging around that a little bit more difficult to understand.

It was outlined that the Trust's underlying position has worsened, but the April planning around medium-term costs model will reset the baseline of budgets in a balanced position for 2022-2023.

13. Draft 2022/23 Finance Plan	**TB (03/22) 011**

The paper was taken as read.

DMc confirmed this process is still underway. Initial ICS submissions for workforce activity and performance were made 10 days ago, and from a finance point of view the Trust is expecting a flat cash scenario. COVID funding will reduce significantly, replaced by growth.

The Trust's assumption at the moment is in order invest in developments they need to deliver more CIP than is nationally required, or to get more income. CIP planning target is £10m, or 1.6% on £600m turnover.

DMc stated the Trust are planning to receive a triangulated activity workforce and finance plan on 17 and 18 March, which will include a very clear expectation that the Trust need to reinstate the grip shown prior to the pandemic around over finance and delivery of plans by system performance, not by organisation.

DMc outlined the follow objectives:

- For people, a 5% increase of workforce and 50% reduction of bank usage.
- For patients, the Trust will reduce long waits, with more work to be done on waiting list, activity volumes and RTT.
- Improvement on diagnostics.
- Urgent care activity volumes.
- Funds allocated for local population health management.

DMc confirmed that on 17 March the Trust will be joining up the pay and the finance plans, with a need to change the finance plan to make sure it reflects the closure of unfunded beds, the fact that confirmed capital is potentially a smaller budget than the spend plan, and the intention to be more assertive in the expenditure plan to assist with securing of adequate budget.

DN queried whether the negotiations are happening with the Black Country and West Birmingham only or whether they are happening simultaneously with BSOL. DMc confirmed they are happening simultaneously with BSOL.

DMc responded to queries around income from emergency care to state focus in on this as a way of resolving 80% of the Trust's cost control issues and cost reduction requirements. It was stated that plans indicate there will be £30m less income next year with £40m additional expenditure, without increasing activity. The Trust therefore need to increase income and drive down costs, with realistic delivery plans in place to achieve this. Zero agency was flagged as an unrealistic target and that agency must instead be minimised with the exception of difficult to fill roles where the Trust has no alternative option.

Discussion was had around the Trust's focus on both medium and short term cost focus. It was confirmed that the MMUH affordability assessment due in April will aim to do this, covering the next four years through to 2026/2027.

LK commented in this regard that the workforce are facing challenges to achieve the ambitious targets they have been set and that innovative thinking is required. DMc confirmed that workforce requirements are being taken into consideration within the medium-term financial plans.

DMc provided reassurance that the objective is to create a balanced financial plan without gaps and advised that the Board will be given opportunity to discuss the plan prior to April's final submission.

DN summarised that 2022/2023 will be a difficult year with lots of risks as the Trust moves into a new paradigm. He advised a comprehensive approach to financial planning is required to ensure connection with the longer term view of the Trust's financial and workforce position over the following three to four year period.

The Board **APPROVED** the executive team to submit a draft plan on 17 March, and agreed to receive the final 2022/23 plan on 18 April, with a three-year forecast.

14. Maternity Improvement Plan	**TB (03/22) 012**

The paper was taken as read.

MR highlighted three main areas to focus on this month's report:

- The Trust are currently at 90% compliance around the Ockenden Report, but will achieve 100% compliance by the end of March.
- The Trust are being asked to offer assurances in relation to the further reports coming out from East Kent et cetera.
- Maternity held a lessons learnt quality improvement event on 10 February and the main thing to note was the interest taken from the Regional Chief Midwifery Office and the CCG who attended that event.
- Update around the safety champions in relation to the maternity safety meetings and walk about the Ockenden framework for January is in the annex for approval.

HR added that the Trust have to submit a further update to NHSE and NHSI by 15 April, so next month's paper requires Board assurance for this. The work undertaken by the governance team should be applauded and this is really building on the work that the Trust has already undertaken on safety culture, ensuring that all members of the team are part of this improvement journey.

HR welcomed Professor Kate Thomas as our new Non-Executive Director and thanked Leslie for her support during her interim time with Maternity.

The Board **APPROVED** the Ockenden Benchmark Rating and Oversight Framework presented in the paper.

15. Hospital Combined Score/Time Series Analysis	**TB (03/22) 013**

The paper was taken as read.

DB advised that the report providers answers on the Trust's combined score. The conclusions drawn were that COVID impacted the Trust significantly in its previous areas of strength. Areas of previous high performance, such as RTT and 62 day cancer, were hit hard. Hospital Acquired Infections are related to an

increase in hospital onset c.difficile. Another key observation was whilst complaints haven't gone up significantly, they benchmarked poorly against peers who saw an average decrease of 25%. The emergency C-section rate is low and it appears no data was submitted during October.

RBe commented that this is a quantitative and benchmarked assessment of where the Trust would be if the CQC inspection process was purely a desktop assessment, rather than comparing against other organisations. He commented that the leadership team have confidence that as a result of an acknowledgement of the current position the improvement work at a granular level is starting to be done.

ML commented there are two areas of the report that need to be explored further:

- Public View make comments on a few other areas;
- Collection of data internally is different from how it's reported externally causing distortions in the report.

Discussion was had around how often the report should be produced. It was commented that the HCS can be accessed on a live basis and a quarterly report would likely be sufficient.

JW queried how long will it take the Executive team to get their head round the issues raised and for the Trust to see improvements being made. DB provided his opinion that the big indicators that are driving the Hospital Combined Score (HCS) have bottomed out and are starting to pick back up already. He believes that by April the Board should have better visibility.

Our people	
16. Our People: Dashboard	**TB (03/22) 014**

The paper was taken as read.

RBe reinforced the point made previously that the commentary needs to be on the SPC trend, not on month to month movement.

The following observations were made by Board members:

<u>20/21 People Pulse staff engagement score</u>

Discussion was had around the next steps in relation to the annual staff survey results now being available. It was mentioned that whilst the Pulse Survey Results are out, the national staff survey results are not out publicly, rather an internal report has been circulated that has been benchmarked against other similar organisations. Staff will be encouraged to send suggestions for areas of improvement based on the results, which will assist with the Trust's action planning response.

It was advised that the POD Board have yet to discuss the benchmarked results, though these will be discussed at the next POD meeting and will be escalated for Board discussion at this point.

MS queried whether the data suggests that the wellbeing efforts are working, particularly in the risk areas of maternity and theatres where engagement was previously low. RW advised that the long-standing issues in maternity are still be worked through but advised significant improvement had been made in the leadership approach to change staff perception.

It was stated that theatre needs further attention with an interventional focus and wholesale review

required.

RW went on to advise however that overall, health and wellbeing tracking shows improvements in both staff perception over the support provided and comfort of staff escalating concerns, though this has stagnated recently. Systems are being considered that will use a variety of measures to ensure this is being managed proactively by the Trust moving forward.

DN commented Board is looking to move this forward to achieve the right level of engagement.

JW suggested that there is scope for the Trust to make significant improvements in the area of engagement, reflecting that other Trusts have made big strides in this regard in relatively short time periods. They expressed their view that to achieve this the Executive team and Board need to be committed to this, as this is not an area where responsibility can be effectively delegated or outsourced.

17. Receive the update from the **People and Operational Development Committee** held on 23rd February 2022	**TB (03/22) 015**

The paper was taken as read.

LW commented it was the first meeting of 2022 and highlighted the following points:

- Work on MMUH - POD could not give assurance because it did not receive sufficient information. Additional information has been requested for the next meeting.
- There was an introductory paper about Retention, but it was felt to be too immature for the Committee to sign off. The Executive team has been asked to discuss it together.
- Staff Survey seeking information from staff. Ruth Wilkin has been co-opted onto POD permanently and the Committee have asked for the next meeting to come up with a comprehensive plan with regard to, (1) how the Trust are going to share the output of surveys with the Board and (2) what the Trust's strategy is going to be going out to staff with the survey as the Committee aims to find a fresh and innovative approach.

LW advised on items requiring escalation to the Board included queries around vaccination that have been addressed previously in this meeting and a lack of confidence around MMUH, which she will bring to the Private Board. It was advised that a decision was made to implement the E-Rostering paper and the Committee were keen to implement this into the organisation as quickly as possible.

RBe commented there are three elements in relation to improving the score for care and staff experience: (1) the six point people plan around culture and values, (2) the digital experience, (3) the physical environment and facilities that staff have available to them.

FM commented that there has been extensive work on the integrated score card because at one point there were no measures in relation to the people agenda at all. They advised that the last three months has seen work on putting together an extensive people and cultural barometer at the request of the Committee.

Our population	
18. Our Population: Dashboard	**TB (03/22) 016**

The paper was taken as read.

DF highlighted that progress had sped up on place-based partnerships.

Further update was provided that work on the outcome measures, a piece of work commissioned from the Joint Strategic Needs Assessment, will be brought to Integration Committee in April.

It was advised that consistency checks have been done across Black Country and West Birmingham with the exception of one place, and that the Trust have will provide support in this regard moving forward.

DF advised that the outcome measures may need some refinement moving forward.

DN confirmed that the Board are **ASSURED** by the report.

19. Placed-Based Partnerships Report	**TB (03/22) 017**

The paper was taken as read.

DF provided update on the report, splitting this into three parts containing the following saliant points:

- A branding name has now been selected of Sandwell Health and Care Partnership, which provides a clear message to people that the Partnership engage with both citizens and partners. As an assurance point it was advised that agreement has been made on one lead GP to represent the GPs. It was confirmed that a draft alliance agreement, partnership agreement of values, behaviours and delivery is well underway and will be delivered within the planned timescales. This alliance agreement is also likely to be adopted by The West Birmingham Partnership to ensure alignment.
- Transformation is moving along at some pace. Good progress is being made on discharge to assess and it was advised the Trust has the best discharge performance in the Black Country.
- Instability in the workforce within the care market is something that should be seen as a risk and opportunity. Opportunities should be looked at as the market stabilises.
- Citizen engagement forums taking place.
- DF advised there was still concerns from local GPs around the situation in Ladywood and Perry Barr.

Discussion was had around the implementation of the Midland Board Level Metrics within the Sandwell Place Based Partnership and whether this then reads across into the Ladywood and Perry Barr Place Based Partnership and whether both Partnerships were aligned and moving at the same pace.

DF agreed that thought needs to be given to the MMUH metrics and advised that with regard to the D2A, parity has been seen across both places and this needs to be maintained to avoid a two-tier system forming. They commented that learning and sharing is happening across the Black Country system and being taken into Birmingham as well. It was advised that the 10 teams have two roles on admission at present, the first being to manage population health to reduce demand on acute service inflows and the second to improve quicker discharge and that these roles will develop further. The virtual ward work and the soon to be launched care navigation service were flagged as two metrics to monitor this against.

RBe queried cognitive dissonance between the information contained within the white paper on place and other reports and asked whether the impending secondary legislation would provide clarity on this. DF advised that he has no clear view on secondary legislature at this current time, but he advised that the white paper is very clear that place should be defined based upon local authority footprints and local

partnerships.

It was provided that there are two ways to strengthen the Trust's work in this regard:

- The Trust does not need to seek permission to do this and that the reorganisation of services that exist as Place is already happening.
- Delegation and accountability is very important at a system level and the Black Country approach as discussed earlier is in conflict to the white paper states and therefore this conflict needs to be highlighted to ensure more control is gained at the Place level to ensure redesign of future services and funding mechanisms is successful.

JW queried whether there is a shared care record, whether this would hold things back and whether there was a degree of clinical risk of not having a shared care record across the system. DF responded that an integration engine called Graphnet has been purchased and will be activated within the next six to eight months to allow a shared care record at Place level, with pilot scenarios being run at other organisations prior to proposed deployment within the Trust in Q1 to Q2 next financial year.

LK raised the issues of disparity between how informed and aligned places are which then feeds back into the ICB system as a whole. DF responded that there are two places in the Black Country that are either at maturity or developing maturity, with the Trust being one of them, with two other places being further behind. It was presented that the Trust has a dual responsibility in this regard:

- To deliver for the Trust's own population.
- To host some action learning principles to scale up as delegation at Place level will not take place until all four places are working at the same level.

Governance	
20. Application of Trust Seal	**TB (03/22) 018**
DCo advised that application of the Trust Seal required approval from the Board. The Board **APPROVED** the fixation of the Trust's Seal.	
For information only	
21. Board level metrics and IQPR exceptions	**TB (03/22) 019**
Noted.	
22. Any other business	**Verbal**
None discussed.	
Details of next meeting of the Public Trust Board:	**Verbal**
The next meeting is to be held on Wednesday 6th April 2022.	

Close

Signed ……

Print ……

Date ……