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Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Localisation and Reconfiguration of Local Services		
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Public Trust Board	Date	1st November 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

The paper reminds us of the case for, and importance of, a single acute site through Midland Met, and the indivisible nature of the planned and diagnostic care centres in West Bromwich, Rowley Regis, and on Dudley Road.

It recognises the issues and opportunities created by a four year delay. This provides the chance to respond to the unmet challenges set out at 1.4 and address the arguably unresolved issues listed within 1.5. Progress has been made but delivery depends on the conditions outlined at 1.8.

The Board adopted a key acute care standard at its last meeting, and the paper outlines progress, not yet concluded, with identifying how we will meet that from 2020, enabled in part through reconfiguration in 2019. We also describe likely changes in paediatric and neonatal care.

With our deepening primary care partnerships the Trust is making increasingly rapid progress to expand local services and meet CCG ambitions that more of their funding is committed to local services, dependent on local employment and local enterprise. Via changed working models and our IT-HIE we want to offer increasing continuity of care between general practice, Trust services and wider care and residential home sector. This is what being an outstanding integrated care system is, and has been since 2015, all about: Our 2020 Vision as a step to deliver the NHS Long Term Plan and Five Year Forward View.

2. Alignment to 2020 Vision *[indicate with an **'X'** which Plan this paper supports]*

Safety Plan	**X**	Public Health Plan	**X**	People Plan & Education Plan	**X**
Quality Plan	**X**	Research and Development	**X**	Estates Plan	**X**
Financial Plan	**X**	Digital Plan	**X**	Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Issues discussed widely in CLE, EG and wider Board committees

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**AGREE** that the Executive can submit initial documents to the CCG for their consideration
b.	**NOTE** the ongoing implementation discussion across the paediatric and physician body
c.	**ACCEPT** monthly updates within the private Board to ensure Group Director involvement

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Various					
Board Assurance Framework		Various					
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 1st November 2018

Localisation and reconfiguration of services

1. Improving quality by reconfiguration: 2022

1.1 The local health system is some years behind in implementing long-standing and widely agreed plans to rationalise acute services. That rationalisation, principally through reconfiguration, will fundamentally do two things – release resource to better support primary and mental health services and put into one place complex acute care. That latter change will improve quality and resilience, because it will bring multi-professional teams into co-location seven days a week. The changes will also largely separate facilities for emergency and acute patients, from those for planned care. Diagnostic facilities will operate across the week, reducing length of stay by removing "red days" from our patients' time in hospital. At that time we will open with a new therapeutic model which emphasis mobilisation and self-care in the activities of daily living. Midland Met is not a transfer of existing service models onto one site it is the creation of a new care model for the local population.

1.2 The reconfiguration was consulted upon extensively in 2006 and 2007. Compulsory purchase secured land in 2009 and the business case was agreed at outline stage in 2014 and full case in 2015, when a contract to complete Midland Met was signed against July completion and October 2018 opening. We now expected to open the hospital in 2022, although if we can secure rapid approval, procurement and mobilisation there may be a small advance on that timetable. The Trust is proceeding with investment in our other estate consistent with the Midland Met business case. Since 2015 we have made major changes in sexual health, cardiac rehabilitation, education and learning, and diagnostic imaging. Looking forward by summer 2019 we will have:

- Completed refurbishment of outpatient facilities in Sandwell and established that site as our ambulatory research centre
- Relocated our city Fracture Clinic into the Birmingham Treatment Centre, completed moves of therapy services, pain medicine and oral surgery, and finished work on the Skin Centre

1.3 **It is recognised that the 2022 model for care locally is indivisible between our sites.** Acute care, most paediatric care, and hospital based maternity care will be based in Midland Met. Most outpatient and diagnostic services, as well as the vast majority of operations and day care, will happen at Dudley Road in the BTC and BMEC, in the Sandwell Treatment Centre or at Rowley Regis. Midland Met is sized and functions <u>because of</u> those other sites' role in local care services. The Midland Met also relies on moves to:

- Support complex patients at home, in extra care or in intermediate care facilities

- Introduce a large scale Urgent Care Centre at Sandwell replacing the present A&E, alongside inter-dependent urgent care locations across the footprint
- Reduce traditional outpatient models, releasing workforce time to acute care, and providing more clinic contact through technology

1.3 The delay to the completion of the build does create an opportunity to ensure that these changes have either been put in place, or can be put in place. The review that we undertook (with GE) as a system in 2017 suggested that:

a) We had established sufficient out of hospital NHS beds in Sandwell and Western Birmingham (excluding Norman Power)
b) We might require some rationalisation of the care sector, which is now being pursued by Sandwell MBC with its proposals for 140 beds across two locations
c) We had innovation in the provision of outpatient care, but had not made material moves to deliver the change in outpatient location, and nor had we seen a localisation of services historically sent out of area (see below)
d) We had addressed length of stay, but continued to see high occupancy and long lengths of stay for some patients, including those with neurological rehabilitation needs
e) We performed well against other Trusts on the specified seven day service standards, but services remained different at weekends, and we were short of the workforce required to operate two A&E functions optimally

1.5 The build delay also creates some additional issues and opportunities, including:

a) The need to complete the investment at Manor Hospital in Walsall sufficient to address the likely displacement of some ambulance patients from Wednesbury when blue light A&E moves to Smethwick
b) The need to address estate repair on the city site, including both neonatal care and critical care, and the need to revisit our IT infrastructure on the interim estate
c) The opportunity to revisit the Birmingham and Midland Eye Centre estate and ensure that its layout and scale are fit for specialised services for the next decade
d) The challenge of decanting the main inpatient stack at Sandwell, ready for new theatres, day-care, and intermediate care wards, as well as the main administrative hub for the Trust's services, and those of partners
e) Delayed land release, either under contract at city, or intended through our car park rationalisation, or enabled by moves across the Sandwell site[1]
f) The opportunity to respond to commissioners' intentions to invest in oncology outpatient and solid-tumour chemotherapy services

1.6 Investment in local primary care facilities was extensive between 2001 and 2010 and when we submitted the Midland Met business case the sense was that community estate was well placed to respond to a reshaped model of care.

[1] This means in practice (a) two thirds of dudley road sold for housing to Homes England (b) redevelopments at Dudley Road once a car park removes the need for flat standing car space and (c) selling Hallam and the associated land for public value

Work since maintains that headline view but does reveal the need to make some more investments in estate to have it ready for Midland Met.

- The Trust's own investment programme at Rowley Regis has been extensive and completed in 2017. There is limited scope to do more and we are working to align our own plans with those of Sandwell MBC across both Rowley and Leasowes in Oldbury.
- At the same the Trust is working to ensure that existing primary care estate is ready for outplaced services, in particular in the locality around the Scott Arms and Neptune in Tipton. More work may be needed too in Wednesbury. We have completed the first phase of some community site rationalisation to bring our community teams together better with local general practice.
- The Trust has a prioritised GP investment proposal supported by the Black Country and West Birmingham STP to relocate Carters Green onto our Sandwell site, and we are also finalising plans to site both a community pharmacy and a general practice on the Dudley Road site.
- We are working alongside partners in mental health to ensure a good fit between our respective estate plans. We continue to explore options to create a dedicated liaison facility, on the model used by colleagues at UHB, in the grounds of Midland Met.

1.7 We have agreed with both the Healthy Lives Partnership board and the Sandwell Health and Wellbeing Board that it would be helpful to refresh the narrative of this clinical storyline, and its estate enablers, so that the "Midland Met population" which sits across two boroughs can be better understood. The initial draft of that work will be complete by the end of November. The key headlines from the Midland Met business remain the founding principles, and approval for Midland Met to proceed is explicitly contingent on the local health system delivering those plans first. Clearly, since 2015 NHS England has revisited and continues to revisit its specialist services strategy, and its payment model. The GE Review of the SWB health economy concluded that stability and sustainability was possible, but drew attention to the potentially destabilising effects of proposed specialised tariff changes.

1.8 In summary, the case for, and delivery of, Midland Met can be achieved in 2022 rather than 2018. That will however demand:

- That we make interim investments to stabilise the existing infrastructure
- That further changes locally to community assets are executed consistent with Midland Met
- That service models and commissioning plans must wrap around the place-based communities that we serve. If not we will create operational and clinical difficulty, and financial disruption

2. Improving access through localisation: 2019

2.1 The Trust remains the primary local provider of secondary care for both adults and children living in two districts of Birmingham, and across the six towns of Sandwell. Most GPs refer most care to the Trust's services. Some services are provided locally by other Trusts, and some services are only available out of area. Whilst distances locally are not especially long or inhibiting, we need to ensure continuity of care, and that the transfer of specialised care to local general services is good, and likewise the transfer of care back to general practice is outstanding. That approach has underpinned our change work for some years now, and is

symbolised by high profile project like DICE and iCares, and by work to wrap services around care homes, and our hope to do the same with local schools. At the same time, we have focused resource on the most vulnerable patients, implementing distinctive services for refugees and migrants, homeless people, and those misusing alcohol or with mental health needs. We have more work to do and remain focused on that, especially for local residents with learning disabilities.

2.2 A significant number of patients receive emergency care from other local hospitals. We have two projects to help to ensure that that happens only where indicated and in patients' long term best interests. We recognise absolutely the choice obligations we have, and that local patients retain.

- We are working closely with West Midlands Ambulance Service. The Midland Met business case, in particular, rested on retaining ambulance conveyance routes presently seen across Birmingham. This was necessary to protect specialist services at the Queen Elizabeth. In addition, the local A&E Delivery Board in SWB is aiming to implement a winter pilot this year that both prioritises Sandwell General for conveyance from Rowley Regis, and gives admission avoidance teams like iCares access to information to prevent hospitalisation. The key benefit of this is to ensure that if someone is admitted to hospital we have the best chance of putting care in place that expedites safe discharge and avoids readmission. At the same time, we will begin in 2019 a dialogue with neighbouring Trusts to understand whether we can offer better access locally to diagnostic and planned care follow up for patients who initially present at a different Emergency Department.

- We are working closely with Primary Care Networks and large-scale provider partnerships. This work is focused on ensuring that we meet the needs of GPs. In particular that our diagnostic access including reporting is faster than presently and faster than other providers. And that our waiting times for first outpatient appointments and for treatment are better than those mandated by the NHS Constitution. We would expect through that our 'share' of local secondary care to rise from around 68% to closer to 85% of need. It was with this is in mind that the Board last month agreed to invest in 100 extra posts across surgery, and the Healthy Lives Partnership is working to support the agreements necessary to make sure that patient and GP needs can be met locally.

2.3 These endeavours need to be matched by our work to transfer aspects of care to primary care. This is not just a relocation of care, but using a primary care workforce and seeking in doing that to deliver continuity and whole-patient expertise. In 2018-19 we have operated a large scale pilot, which may be near unique in the NHS, under which Modality has provided follow up care to many patients referred into key specialties at the Trust. We would expect to replicate that proposition with other GP networks during 2019-20. At the same we are negotiating with imaging providers locally to see if we can establish a single system to diagnostic provision which aims to share scarce workforce expertise and to prevent images needing to retaken which is wasteful. The Trust is simultaneously undertaking work to source secured reporting supply for imaging.

3. Improving quality through reconfiguration: 2019

3.1 The Board is familiar with clinically-led analysis that we began in February 2018 of our services' risk profile given the significant delay to Midland Met. That work has been consistently shared with Sandwell and West Birmingham CCG staff, as well as those nominated from NHS Improvement and NHS England. It has also been discussed twice with Joint Overview and Scrutiny Committees, and referenced within the HWBB.

3.2 In parallel there have been various nationally initiated NHS wide exercises examining service sustainability or vulnerability. This includes, but may not be limited to, questions via HEE, NHS Improvement and the regional NHSE team. As a Sustainability and Transformation partnership we sought to establish one route for such consideration and the Trust has contributed to that ongoing thinking, which was presented to the Q2 STP Stocktake chaired by Dale Bywater. Within that work we highlighted potential weaknesses in the following areas, derived from workforce gaps:

- Acute medicine and emergency care (both adult and children)
- (ENT) Ear, Nose and Throat surgery with staff moving to neighbouring Trusts
- Radiology, and in particular paediatric and specialist reporting
- Interventional radiology, absent vascular access
- Some sub-specialist surgery including paediatric ophthalmology, sub-specialist urology, and aspects of plastic surgery

3.3 Progress has been made in ophthalmology. ENT has been discussed with the Board routinely, and we will work with regulators to convene a risk summit over the next two months. It is however imaging, and acute and emergency care, where the impact of difficulties is felt well beyond that specialty. The future shape and model for imaging will be presented to the January Trust Board once we have completed work to confirm the performance standards that we want to meet in collaboration with primary care, and after initial market engagement about reporting provision from abroad.

3.4 Paediatric services for acute care span paediatrics itself, and the allied provision of neonatal services, and then attendance at A&E. The Trust offers a consultant delivered paediatric service on both sites, but support to the assessment facilities at City is delivered in combination with the neonatal unit. That service is located at City because it needs to be adjacent to maternity. The service at Sandwell supports our acute wards. 0900-2100 Children's A&E provision is offered at both sites, but can be stretched by staff absence, and the CQC have questioned how best to offer services to children overnight. Our arrangements are very much consistent with most District General Hospitals in the NHS and the volumes attending overnight are small. Nonetheless we need to ensure that our employees have confidence in their skills with children and we need to make the best provision that we can for environmental separation. The issues are resolved by the opening of Midland Met which not only has distinct provision, but locates Emergency Department, paediatric wards and neonatal facilities on the same site. We are exploring presently the technical and estate feasibility of two changes in advance of that opening.

- One resolves environmental issues with the neonatal unit and will be explored further in an upcoming Trust initiated Safety Summit.
- The second would seek to co-locate the paediatric assessment beds and paediatric A&E at City and remove the Arches Entrance to the site, or relocate it.[2]

This will not tackle any issues at Sandwell out of hours and we are developing with neighbours at Walsall and Russell's Hall potential staff training packages to enhance the skills and knowledge of adult based Emergency Department nurses.

3.5 The Board has discussed the options that we are exploring to address acute medicine and A&E. On our current staffing we can provide at least one Emergency Department consultant on each site, on each shift, with on-call cover from 22.00. This is safe but less than optimal and we are seeking to ensure that we provide a senior decision making capacity at the front door. SMART has begun, using specialist senior registrars. The CESR investment made by the Board has created a better prospect of being able to sustain that workforce and provision. Nonetheless, the longstanding risk register entry for Emergency Department medical staffing remains at best amber, and the recent recruitment exercise at consultant level produced not a single applicant. Accordingly, we can reach two conclusions:

- We can support two A&E departments with existing staffing but would need to revisit their hours or role if staffing materially deteriorated. Confirmation of Midland Met provides a basis for seeking renewed recruitment, and we will work to address other issues about how our A&E function which may deter applicants, both by ensuring that we have the right infrastructure to manage non-A&E patients outside A&E, and by creating rewarding roles with coherent rotas that provide both time to undertake learning and research work, and a lower likelihood of needing to attend site during on-call.

- We need anyway to develop a final workforce model for the Urgent Care Centre which we will be running from 2022. Should we be unable to sustain both A&Es some form of function of this nature may need to be operationalised sooner. The investment to develop Emergency Nurse Practitioners is in place and will be implemented from early 2019. We need to work with partners to finalise the medical model which will be grounded in, but may not be wholly resourced from, local general practice.

3.6 We cannot currently be confident that any patient admitted into our Acute Medicine Units is seen at consultant level within 14 hours. This is the 2018 standard that the Board has adopted, recognising that that ambition is higher than national norms, but is the promise that we made in 2015 for 2018. It is driven by a belief that senior clinicians seeing patients at the outset of care plan will make more risk-based judgements not just about immediate treatment, but about the capacity of a patient to be looked after at home or in their community with support. On a seven day a week basis it is not possible to see how our 8-9 acute physicians (this is expected figure from April 2019) would be able to see patients across 110 beds, given an arrival pattern which has two peaks – late morning and early evening. There is a possibility of building a model to that end on a five day a week basis if

[2] The draft arrangements would offer entry via the BTC and via the main car park into the spine. A smaller access at the front may be preserved.

we can reach our target acute medicine staffing of 12. That figure has not been nearly reached in the last five years despite our excellent training reputation. At the same time our general internal medicine rota performs three functions in support of both the wider bed base and acute medicine:

- Offering some sessional input into acute medicine
- Holding the site wide consultant bleep out of hours, excluding ED and CCS
- Contributing to post take work on Saturdays and Sundays

3.6 That general input is not consistent with our stroke rota, has no haematology, cardiology or neurology input, is not delivered by all diabetes consultants, and is not consistent with specialty direction in gastroenterology. Put differently, it forms a key part of the future of acute medicine, geriatric medicine and respiratory medicine. Together these specialties form the majority of the receiving disciplines for those admitted, requiring assistance from other medical specialties, as well as nephrology and acute oncology.

3.7 At the same time, the Trust has successfully grown ambulatory acute care over the last two years. This demands senior medical staffing and acute assessment skills. It is in effect an additional lure and additional demand on acute medicine. We have been successful in developing specialist nurses in this field, and may have scope to expand the sessional input of general practice here too. Our A&E diversion work, and hot clinic provision, is located presently (for medicine) in our Acute Medicine Ambulatory Assessment unit. We believe that there is some scope to alter that by using specialist cardiac nurses differently across both Acute Medicine Unit and Emergency Departments.

3.8 Finally, beyond the Critical Care unit at levels 2 and 3, all of our monitored beds for acutely unwell patients are located in the Acute Medicine Units, other than the NIV facility we created last year at Sandwell. This too is a 'competing' time issue for acute medicine, and the Trust's Critical Care Board is seeking to resolve the long term direction of these beds in Midland Met. In all probability that will retain some such beds in AMU, and locate some others within one of our future medical wards.

3.9 A fortnightly clinical group is now meeting to examine how we can:

(a) Create generalist capability to see patients rapidly either in the first in ED or within 14 hours in acute medicine, or both – 7 days a week

(b) What frailty models we will implement at Sandwell, City and in Midland Met and how they support that generalist work

(c) Whether single site location for most respiratory medicine at City would create an opportunity to devote time more efficiently in that specialty into acute medicine

(d) How GI care will be organised in Midland Met, and whether a combined medical and surgical unit will be created

3.10 To be explicit the volumes involved in any reconfiguration are expected to be very modest. The conclusion of that option generating work will allow us to:

a) Confirm ward refurbishments arrangements needed at City Hospital and initiate work with funds provided through DHSC and the STP
b) Confirm AMAA and other estate investments consistent with the issues above
c) Make recruitment and job plan changes consistent with a finalised model for acute and emergency care
d) Commence detailed discussions with the CCG and other bodies about processes leading to engagement with the public needed during February, March and April
e) Confirm with clarity a description of the 2022 Sandwell emergency care model through the Urgent Care Centre, such that any public engagement can discuss both present services, interim arrangements and inform on the final state

4 Investing in estate sustainability: 2019-2022

4.1 The Trust has a detailed capital programme which is routinely refreshed. The timing of investments had changed since 2015, but the scale has largely remained the same, notwithstanding the addition of a handful of items. Those plans do not take account of oncology decisions made latterly. The programme will require further refresh in view of our IT resilience issues. A final revised programme will be prepared in February 2019 for submission within the FBC LTFM.

4.2 The Board has agreed developments around car parking at both City and Sandwell and planning applications for those facilities will go forward in due course. A masterplan report about the city retained estate is currently being considered and will come to the January Trust Board.

4.3 Subject to written confirmation of the infrastructure and reconfiguration investment submission made by the STP, we will commence works early in 2019. To assist in that we aim to shortly complete:

- Estate MPA review of statutory recommended investments at City 2019-2022
- Confirmation of IT infrastructure works for retained and interim City estate
- Costing of paediatric, neonatal and ward refurbishment plans to keep the city estate functional clinically to 2022

4.4. December's Clinical Leadership Executive will be invited to help prioritise the decisions that we need to make before the final budgeting is concluded. January's Board will review final proposals.

5. Conclusions and recommendations

5.1 This paper sets out the context, history and current state of service configuration, vulnerability and estate dependency. It outlines both emerging solutions and processes by which decisions will made between November and February.

The delayed timeframe has allowed us to take account of both revised commissioner expectations and the likely conclusions of the CQC. None of that alters three key positions which are the backdrop to our next steps:

- 70% of Trust services are rated good or outstanding and the exceptions to that lie predominantly in acute care. The status quo is safe but not good enough on a seven day a week basis.

- Midland Met was and is a key solution to those issues and we are fortunate to have funding made available to take expedient interim steps to improve services, and decisions on those steps, though delayed, are imminent.

- By 2022 the Midland Met will be in place, but its functionality is indivisible from the balance of our estate which will provide local and planned care services to a growing population in partnership with primary care.

5.2 Against a backdrop of an already agreed maximum spend we will take advice on estate risk via the Board's Major Project Authority, and then fit that spend alongside our IT infrastructure and service reconfiguration expenditures. The latter will be prioritised through the Clinical Leadership Executive.

5.3 We wish now to begin a detailed discussion with the CCG governing body about:

- A&E sustainability, and specifically the workforce model for the 2022 Urgent Care Centre (bearing in mind impending procurements)

- Configuration arrangements for acute and respiratory medicine

- Assurance arrangements for paediatric acute care

5.4 The Board should be assured that we remain determined not to simply await the arrival of Midland Met before addressing the service shape, outcome and experience issues that we have long recognised.

Toby Lewis
Chief Executive
October 26th 2018