Paper ref:	TB (08/19) 016

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Organising acute beds to 2023		
Sponsoring Executive	Toby Lewis, Chief Executive		
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Meeting	Trust Board	**Date**	1st August 2019

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

This item introduces a series of Board papers for discussion which seek to:

- Connect the work we do in our Sandwell community teams to our inpatient bed base and the patients admitted as an emergency to our care
- Connect the immediate winter plan work we are doing to our move into Midland Met

Whilst the papers are presented on the basis of patients and services, there is an important staff and career pathway consequence to our decision making. As we move towards a deal for Midland Met we want to be able to talk to colleagues about their personal future in the new facilities and the training investments we are making to help develop their skills and career.

In 2018-19 we successfully reduced average length of stay and increasing use of ambulatory facilities. However, rising admission numbers in a population with above expectation hospitalisation numbers place pressure on the model, and our work to better connect our care with Care Homes will be one of several programmes to seek to address this in 2020.

I would suggest that at the conclusion of all the related items we consider the key messages and decisions needed.

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

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

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

Clinical Leadership Executive

4. Recommendation(s)

The Trust Board is asked to:

a.	**SET** the presented work in the context of our summer 2018 bed state workshops
b.	**NOTE** the intention now to execute the planned interim reconfiguration
c.	**ENDORSE** the aspiration to connect community and acute population health work and agree an expectation that during 2019 we are able to offer our ward based staff a clear route to 2023

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

Trust Risk Register							
Board Assurance Framework							
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 HOSPITALS NHS TRUST

Report to the Trust Board: 1st August 2019

1. Introduction and background

1.1 In July 2018 the Board reviewed our acute care plans for the medium term and recognised that the transition to Midland Met would require a renewed medical generalism and inter-disciplinary working between specialties. We envisaged a move to seven day services. Both themes are well represented in the subsequent NHS Long Term Plan.

1.2 In August and September 2018 we completed our analysis of the enhanced clinical risks posed by the delay to Midland Met, from October 2018 to June 2022, and our ability to safely sustain services across two A&E departments, acute medical units and general hospital sites four miles apart.

1.3 Our CQC Review from 2018, published in April 2019, simply reconfirmed the dichotomy of ratings within the Trust's portfolio between both community services and single discipline acute services, which are all now rated as Good or Outstanding, and general acute care, which is no longer rated as inadequate in part, but as a whole still Requires Improvement. That then stands in the way of our aim to be rated Good in 2019, an aim now targeted for 2020.

2. The short to medium term strategy

2.1 We have worked hard to establish alternatives to acute hospital care and hospital admission. We have had success with our work on ambulatory pathways – indeed the dramatic rise in these alternatives was latterly the cause of a deterioration in the numerator for our HSMR. We have had success with our Single Point of Access supporting GPs to use services other than A&E. Re-admission have fallen as has length of stay. In other words, we have proven that we can have material impact through innovation and change.

2.2 On the other hand, occupancy remains extremely high, and the move to Midland Met is modelled on a material change to that occupancy, as we look to reduce pressure on our staffing teams, and to improve the experience of care. Programmes such as Red to Green, as well as LACE, and OPAU, have shown promise but not been sustained. Consistency of Care, as a programme, across medicine has sustained results at the bedside on the key metrics that we track daily. But it has not sustained initial 2017 gains on creating local ward leadership from both doctors and nurses working together. This year we renew that intent through the work of our Executive Quality Committee.

2.3 Progress has been made in the care of older people. Our four hospital older peoples' wards across both hospital sites now work to common standards as a cluster. Physicians now rotate between the sites, and we have a clear sense of shared purpose and ambition. But our Frailty model remains patchy and not always clearly described, which is why we have joined the STP Frailty Collaborative, and committed to focus attention initially on the pathway and offer at Sandwell.

2.4 The Midland Met risk work identified older people's medicine as one risk area, and A&E recruitment as another. Both were considered broadly amber rated risks. Our red rated risk was acute medicine, and this view was amplified when we decided that the 14-hour standard should be applied consistently in our Trust, seven days a week, and at consultant level. That drives a workforce model for which it is now clear that the specialty pipeline alone will not deliver in the next five years. That clarity has driven repeated and engaging discussions about the future of acute, older peoples' and respiratory medicine as a triple team working to manage admitted acutely unwell adults.

3. The Midland Met strategy

3.1 The new hospital will span nine floors. It contains a large ambulatory space on the ground floor and scope to implement a second major ambulatory zone on the ninth floor. The acute admissions beds number over 100 and represent a 48-hour admission area that we must staff consistent with good flow and good experience of care. Our longer stay wards, both in MMH, and in our 200 community beds, need to be shared by those people whose best interests require longer term admission, and who cannot credibly obtain that therapy at home or in a care or residential home.

3.2 On current admitted numbers and current length of stay the Full Business Case shows that we have sufficient beds to manage need. But over a five to ten year forward look a rising and ageing population demands that we either use our beds with even greater efficiency, or implement strategies now to reduce need and manage demand more smartly. It is in that context that we consider later a paper on how far our emergency and admitted populations are "known to us", in this case through CHS, and in due course through primary care, or to what extent acute exacerbation and admission was unforeseen or unforeseeable.

3.3 The move to Midland Met requires a Fully Staffed scenario and it requires good relationships and skills between teams we employ, and those with partner organisations. To that end, we want to help our current staff to have confidence not only in the clinical model for the future, but in their own personal future within our wider vision. That drives a desire to settle remaining configuration questions not only for 2019 but also for the layout inside Midland Met in 2022.

3.4 One of the promises of the single acute site at Midland Met was that it would permit us to better wrap services around admitted patients because they are in one place and so are our acute teams, seven days a week. Similarly we indicated that by separating acute diagnostics and support teams from planned care services which broadly remain at Sandwell TC and in the Birmingham TC, we would release capacity and pace. The paper later on acute care standard starts a doubtless long walk towards a set of services able to respond in time to need and to learn how to flex to meet day on day variation. That of course must include addressing the weekend questions that all public services organisations are facing presently.

4. Conclusions

4.1 It is improbable that any of the ideas in the follow-on papers are ones that we would wish to reject. The question is whether they are collectively sufficient to the acute care challenge our population faces.

4.2 Having established that full suite of what must be done, we need a cohered mobilisation to do it all, at scale and in sequence. This acute transformational programme is not yet completely developed, and is not solely a hospital or Trust activity. The papers today provide a direction and a steer.

4.3 The pressing winter issues arising from the now sustained but large rise in emergency admissions at the Trust, as elsewhere in the UK, brings these debates into immediate focus. They are a reason to implement the same strategies at greater pace, rather than to make different directional decisions. The leadership of our CCG have indicated in principle support for the ideas we are discussing, and similar propositions go to the CCG Governing Body on August 7th. Having an acute care strategy on the front foot remains our approach.

4.4 Currently across our STP we are examining how we might organise emergency care implementation better. My sense is that place based A&E delivery boards will dissipate into a single system wide body. Partners are then exploring how an acute care focused local forum could best drive improvements in care for admitted patients, as well as acute care for children and those in mental health crisis.

Toby Lewis
Chief Executive

26th July 2019