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Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Population Health: One coordinated care pathway		
Sponsoring Executive	Rachel Barlow, Chief Operating Officer		
Report Author	Tammy Davies, Group Director, Primary Care, Community and Therapies		
Meeting	Trust Board	Date	1st August 2019

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*
Excellence in community care is defined as accessible, coordinated and patient focussed with provision tailored to meet the needs of the local population. Sandwell and West Birmingham is a diverse community where residents experience ill health and death earlier than in most areas. In order to contribute to improving this position, Sandwell and West Birmingham community services will need to ensure accessibility to all people. An evaluation of the current composition of the adult community caseload is presented and compared to the local population. Strategies to engage with underrepresented groups through the further development of 3rd sector organisations and community groups will be required to improve the current position Streamlining pathways between acute and community services are required to ensure community services are available to the right people and the right time

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		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

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

4. Recommendation(s)	
The Trust Board is asked to:	
a.	**DISCUSS** the current composition of the community caseload in comparison to the local population demographics
b.	**NOTE** current pathways between acute and community care
c.	**DISCUSS** proposed objectives to improve access to services

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*								
Trust Risk Register		n/a						
Board Assurance Framework		n/a						
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

Population Health: One coordinated care pathway

1. Introduction

1.1 Sandwell and West Birmingham NHS Trust (SWBH) deliver adult community services throughout Sandwell and via selected services to West Birmingham. Community teams see an average of 618,000 patients each year, offering a range of services including:

- District Nursing (Sandwell only)
- Palliative and End of Life Care (Sandwell and West Birmingham)
- Respiratory services (Sandwell only)
- Continence services (Sandwell only)
- Diabetes (Sandwell only)
- Dietetics (Sandwell only)
- ESD Stroke services (Sandwell and West Birmingham)
- Foot Health (Sandwell only)
- Heart Failure (Sandwell and partially West Birmingham)
- Integrated Care Services – (Sandwell only)
- Musculoskeletal services – (Sandwell partially West Birmingham)

In addition there are 6 community wards providing intermediate care and care for people who are medically stable but require on-going care and nursing intervention prior to final destination discharge.

1.2 Excellence in community care is defined as accessible, coordinated and patient focused, maximising quality of life and enabling care closer to home. The following paper will describe the position of Sandwell and West Birmingham NHS Trust (SWBH) in relation to these standards, providing future steps for improvement.

The paper will only include services provided for adult patients.

2. Comparison of community caseload to local population data

2.1 According to the **latest demographic information** provided by Sandwell and West Birmingham clinical commissioning group (SWBCCG), residents are amongst the most deprived in England with 60% living in areas classed as the 20% most deprived in the country. The population is diverse with 50% of the population classed as white British compared to 87% nationally. Over 46 different languages are spoken and several different religions followed. Sandwell and West Birmingham residents receive lower

levels of education compared to England. It is estimated that 6-10% of the local population identify as lesbian, gay, bisexual or transgender (LGBT).

2.2 **Residents of Sandwell and West Birmingham have significantly worse outcomes compared to national levels**, with life expectancy 2.4 years lower in men and 1.3 years lower in women. In addition the years that people live disability free, at an average of 57.4 years, is 5 years younger in men and 6 years younger in women than the national average. In 2016/17 70% of Sandwell residents were overweight or obese and current estimates indicate the 27% of the SWBCCG population are obese.

2.3 In order to contribute to the improved health of the local population, community services are required to be accessible to all groups. However, national data indicates that access to health care is inequitable with those from minority ethnic groups, those with first language other than English and those with lower than average educational attainment not accessing services as frequently.

2.4 A comparison of the local population and the current community caseload has been undertaken in relation to ethnicity and religion to determine if groups are adequately represented. Maximum educational attainment is not collected for patients and so could not be compared.

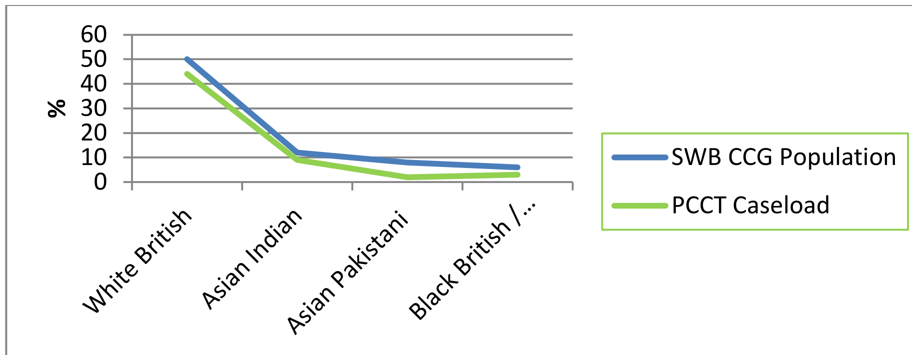
2.5 **Ethnicity** is recordable as part of the minimum community data set but of the current community caseload 24% had no recorded ethnicity.

Ethnic origin for community patients by individual caseload

Ethnicity	Connected Palliative Care	Respiratory Services	Sandwell Community - Continence Service	Sandwell Community - Diabetes	Sandwell Community - Dietetics	Sandwell Community - District Nursing BCCN	Sandwell Community - District Nursing O & S	Sandwell Community - District nursing WWB	Sandwell Community - ESD Stroke Service	Sandwell Community - Foot Health	Sandwell Community - Heart Failure	Sandwell Community - Integrated Care Service	Sandwell Community - Musculoskeletal	Grand Total
African	2	4	3	14	7	1		2		45	2	16	111	207
Any other Asian background	10	1	3	40	9	1				136	6	1	59	266
Any other Black background	18	6	18	38	20	4	8	11		224	11	26	296	680
Any other ethnic group	16	12	24	39	20	8	14	9		223	18	51	304	738
Any other mixed background	122	83	121	48	73	90	58	104	3	763	122	167	393	2147
Any other White background	35	69	58	101	80	54	11	39		1105	78	156	485	2271
Bangladeshi	9	6	2	22	19	2		7		79	3	8	196	353
British	626	715	903	724	587	615	328	662	13	8517	614	1584	4191	20079
Caribbean	35	14	39	78	34	8	31	22	1	473	24	58	285	1102
Chinese	1			1	1		1			5		2	10	21
Indian	87	49	74	336	117	19	54	48	3	1455	68	195	1563	4068
Irish	8	15	9	9	7	3	6	6		83	6	13	31	196
Not Stated	29	38	80	64	59	58	26	23	1	712	38	192	261	1581
Pakistani	24	13	11	76	42	8	17	6		308	20	46	461	1032
White and Asian	1	3	1	5	5		2	2		18	2		23	62
White and Black African			1	1				1		7			12	22
White and Black Caribbean	3	2	7	7	10		3	3		62	4	6	72	179
Not recorded	235	439	319	1306	1022	108	37	89	29	2064	262	490	4751	11151
Grand Total	**1261**	**1469**	**1673**	**2909**	**2112**	**979**	**596**	**1034**	**50**	**16279**	**1278**	**3011**	**13504**	**46155**

2.6 The 4 most prevalent ethnic groups found in the area are represented consistently across community services, with the only underrepresentation attributed to the Asian Pakistani group. However, it is noted that the majority of this cohort are located in West Birmingham where SWBH community services have less of a footprint.

Percentage of patients in from the 4 most prevalent for the population of SWBCCG and community caseload



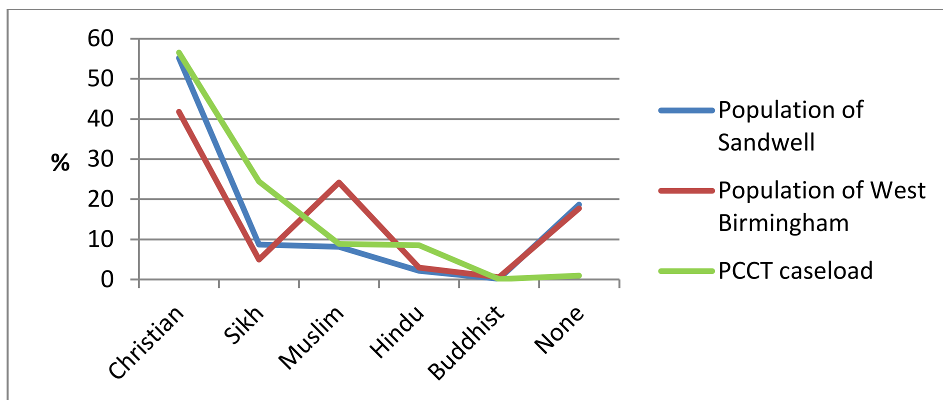
However, despite a favourable position for combined community services the percentages of white British patients across all district nursing clusters (62%) is higher than the population percentage (50%) and the combined community caseload (44%). A more detailed analysis of the areas covered by these teams is required to identify a root cause.

2.7 The prevalence of all **major religions** are at higher rates than reported for the populations of both Sandwell and West Birmingham with the exception of Islam. There are significantly higher percentages of Muslims in West Birmingham compared to the community caseload which is likely to be attributable to the reduced community footprint in the area. However, it should also be noted that religion is not recorded in a large number of patients on this caseload (93.4%). This calls into question the potential for selection bias.

Recorded religion for patients active on the community caseload

Religion	Grand Total
Anglican religion	141
Atheist	30
Baptist religion	60
Buddhist religion	3
Catholic religion	1
Christian	179
Christian religion	297
Church of England	55
Hindu	258
Islam	265
Jehovah's Witness religion	53
Lutheran religion	0
Methodist religion	190
Mormon religion	2
Orthodox Christian	6
Orthodox Christian religion	8
Pentecostalist religion	88
Presbyterian religion	10
Quaker religion	147
Religion (Other)	9
Religion NOS	4
Roman Catholic	434
Seventh day adventist religion	10
Sikh religion	727
Sunni muslim religion	1
Unitarian religion	2
Not recorded	42703
Grand Total	45683

Percentage of patients belonging to the most prevalent religions



2.8 It is difficult to determine if people who do not have **English as a first language** are accessing services equitably. Local population data describes 6% of residents not speaking English but community caseload data only records first language and does not consistently describe if English is also spoken. From the data available 86% of patients describe English as a first language, 8% Punjabi, 1.7% Urdu, 0.9% Bengali, 0.8% Polish

2.9 It has been estimated that over ¼ of all immigrants in Sandwell are Polish. The percentage of patients speaking Polish as a first language recorded on the community caseload is low suggesting that residents with Polish nationality may not be accessing services. However, this assumption is difficult to substantiate as the exact numbers of Polish residents is not available. In addition the age and health profile is not fully understood and so the Polish population may be largely younger with less health needs. Nevertheless, it is an underrepresented group and further exploration is required.

2.10 There are a greater number of female patients on the community caseload (57%) compared to 50.7% in the local population.

2.11 **LGBT** status is not consistently recorded for community patients and a comparison to local population cannot be accurately provided to determine accessibility.

2.12 There are several areas where demographic information is not available for the local population and / or the community caseload. For example it is widely documented that homelessness is rising nationally and although definitive numbers are unknown, it is estimated that homelessness has increased 9 fold in Birmingham and 6 fold in Sandwell between 2010 and 2018. In comparison there are currently no patients on the community caseload described has having no fixed abode. It is also unclear if any asylum seekers are receiving community care.

2.13 Despite favourable demographic comparisons between the community caseload and local population in a number of areas further analysis is required to ascertain if outcome measures are equitable across the demography. It is suggested that further analysis is undertaken to compare quality of life for all groups.

2.14 There is a lack of uniformity when recording patients with **disabilities** making it impossible to accurately quantify the number of patients with learning disabilities. In addition there are currently less than 1% of patients on the caseload who are categorised as either deaf or blind which possibly indicates reduced access for this group.

2.15 There is currently significant variance across community teams in the recording of behaviours and indicators of future morbidity. For example body mass index (BMI) is not consistently recorded. National and local intelligence predicts that **obesity** will become increasingly prevalent with associated widespread risks to public health. It is, therefore, imperative that future planning of community services incorporates the obesity strategy. Community staff are well placed to provide support and advice for patients with raised BMI during routine contacts and in addition to work with community and 3rd sector groups to educate at scale.

3. Sandwell and West Birmingham NHS Trust Community workforce

3.1 A workforce representative of the local community is advantageous for the achievement of services which meet the needs of the population. Improving access to care can only be achieved if services are planned in partnership with local residents and those who deliver services develop an understanding of service users, developing ways of communicating with underrepresented groups.

3.2 There are currently 1051 staff in post in the Primary Care, Community and Therapies clinical Group responsible for delivering adult community care, including medical, nursing, therapy and clerical / support staff. The **ethnicity** of the workforce is diverse with a slightly higher percentage of white British (57%) compared to the local population (50%). There are 3.5% of Asian Pakistani staff compared to 9% locally. Of note there is only 1 Polish staff member.

Ethnicity of staffing working within the Primary Care, Community and Therapies (PCC&T) clinical group

Ethnicity	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8 - A	Band 8 - B	Band 8 - C	Other	Grand Total
A White - British	65	82	45	109	143	99	29	4	3	19	598
B White - Irish	1	1			2	2				2	8
C White - other		1	1	3	6	5	1	1		1	19
CP White Polish			1								1
D Mixed - White & Black Caribbean	5	2	4	7	2	2					22
E Mixed - White & Black African	1			1	2	1					5
F Mixed - White & Asian		1	1		2	1		1			6
G Mixed - other	1	2	1	1	1	1	1				8
H Asian or Asian British - Indian	15	24	6	17	17	14	2	1		17	113
J Asian or Asian British - Pakistani	9	9	1	8	4	1				5	37
K Asian or Asian British - Bangladeshi	4	2			1						7
L Asian or Asian British - other	1			4	5	2				1	13
LH Asian British	1										1
M Black or Black British - Caribbean	22	8	5	29	18	7	3			2	94
N Black or Black British - African	12	3		18	7					1	41
P Black or Black British - other		1		3	3						7
R Chinese				1						3	4
S Any Other Ethnic Group	1	1		6						1	9
SC Filipino	1			1							2
Z Not Stated	9	6	4	12	6	5				13	53
Grand Total	**148**	**143**	**69**	**220**	**219**	**140**	**36**	**7**	**3**	**65**	**1050**

3.3 In line with both national and Trust data staff diversity is not consistent across pay bands with significantly higher numbers of white British staff in positions of band 7 and

above. Work is on-going to ensure equal opportunities for all staff; for example through staff networks, The Stepping up programme and mandatory diverse interview panels.

3.4 The **sexual orientation** of the community workforce indicates that there is a lower proportion of LGBT (3%) compared to local residents (6%). However, this information was not recorded in 28% of cases.

Sexual orientation of staff working within PCC&T

Sexual Orientation	Total
Bisexual	6
Gay or Lesbian	13
Heterosexual or Straight	732
Not stated (declined to answer)	294
Other sexual orientation not listed	1
Unspecified	4
Grand Total	**1050**

3.5 In terms of **religious beliefs,** 66% of staff identify as Christian which is 10% higher than Sandwell and 13% higher than Birmingham. However, the numbers are comparable to the local population for Hinduism and Sikhism. There are lower percentages of Muslims in the community workforce (5%) compared to both Sandwell (9%) and West Birmingham (24%)

4. Engaging with local communities

4.1 Despite the largely favourable picture of the community caseload in regards to representation of most commonly occurring ethnic and religious groups, there is a lack of a clear understanding regarding the needs and access for people in smaller minority groups.

4.2 The Trust has a proven record of working in partnership with 3rd sector organisations and community groups with a long term strategy of strengthening these relationships through care alliances. In areas where there are particularly strong networks there is a correlation with improved access to services for the associated population. For example, the Trust has strong ties with the West Bromwich African Caribbean resource centre and has an established relationship with local religious centres such as Nishkam.

4.3 There are several areas of the community where networks or groups exist but the Trust, as yet, has not developed robust relationships and there appears to be a correlation between this and underrepresented patients on the community caseload. In particular, groups which represent new and emerging communities such as Somalian refugees and Eastern Europeans.

4.4 In order to ensure that new and emerging communities have equitable access to community care, collaborative work across the local health and social care economy is required to reach communities. For example, through sharing data and contacts with Primary Care Networks and local councils.

4.5 Trust staff networks have contributed to a greater understanding of the needs of specific patient groups with robust LGBT and BME arrangements. Additional staff networks such as an Eastern European network of staff is proposed to contribute to recruitment and greater insight into the needs of this area of the population.

4.6 It is suggested that the main obstacles to accessing community services for underrepresented groups include difficulty in navigating the system (particularly for those who do not speak English) and a poor understanding of specific needs by staff. In order to overcome these issues, engagement with community groups is vital to ensure that people from minority groups are involved in planning services. Further engagement across the 3rd sector and community groups is required.

4.7 Strengthening relationships with community groups and 3rd sector organisations would facilitate a clearer understanding of different communities with regards to culture and obstacles to accessing care. Listening to the needs of the population and involving people directly in the planning of services would ensure future provision which meets the needs of the population. It is proposed that a mapping exercise is undertaken to determine where there are less robust links to the local community and where this corresponds with underrepresented groups. Results would inform focussed work to strengthen networks.

4.8 Sharing skills and developing pathways with providers of mental health and learning disability services is proposed to reduce inequalities and improve outcomes for patients. Discussions are underway with Birmingham and Solihull mental health Trust to develop collaborative working.

5. Strengthening pathways between acute and community services

5.1 Despite the range of community services offered by Sandwell and West Birmingham NHS Trust it is recognised that there are a number of patients, who despite having a defined community care requirement, are not referred by their discharging ward. Analysis of the previous 12 months showed that of the 39413 adults attending both City and Sandwell Emergency Departments (ED) 22% had been known to community services with 7.6% currently active on a community caseload. Sandwell ED had a larger percentage of patients known to community services (30%) with 10% currently active. This smaller numbers at City are attributed to the reduced provision of community services by SWBH in this catchment area. 24% of patients on the community caseload attending ED were readmitted within 30 days.

Patients attending ED between June 2018 and June 2019

		ED Admissions		Known to Communit		Known to Communit		Readmission within		Total ED Admissions	Total Known to Community Prior admission (from April 2017 onwards)	Total Known to Community Prior admission (active Patient)	Total Readmission within 30days (those known to community)
Calendar_	Month	City	Sandwell	City	Sandwell	City	Sandwell	City	Sandwell				
2018	June	1294	1608	130	449	34	114	8	25	2902	579	148	33
	July	1359	1680	170	471	52	121	11	26	3039	641	173	37
	August	1377	1652	154	474	47	143	15	32	3029	628	190	47
	Septembe	1267	1467	146	442	41	133	4	29	2734	588	174	33
	October	1268	1509	172	440	47	124	16	21	2777	612	171	37
	Novembe	1289	1631	167	517	53	151	19	41	2920	684	204	60
	Decembe	1468	1736	193	574	60	185	15	45	3204	767	245	60
2018 Total		9322	11283	1132	3367	334	971	88	219	20605	4499	1305	307
2019	January	1594	1799	192	568	58	188	8	50	3393	760	246	58
	February	1288	1629	145	493	57	161	12	49	2917	638	218	61
	March	1433	1758	158	538	76	181	20	42	3191	696	257	62
	April	1350	1832	172	599	67	236	17	59	3182	771	303	76
	May	1322	1845	170	553	60	265	14	72	3167	723	325	86
	June	1272	1686	176	496	89	248	19	52	2958	672	337	71
2019 Total		8259	10549	1013	3247	407	1279	90	324	18808	4260	1686	414
Grand Total		17581	21832	2145	6614	741	2250	178	543	39413	8759	2991	721

5.2 The 48 hour follow up pathway which involves community staff contacting all patients discharged from acute wards is currently being rolled out. During the first 6 weeks a phased approach was adopted with additional acute wards added every 2 weeks. Initial results indicate that there is a significant cohort of patients not known or referred to community services identified as having a community need. This initiative will be rolled out across Sandwell with the objective of providing community services to those with unmet needs and reducing unnecessary acute readmissions

Data from 48 hour project

KPI	Data
Number of patients contacted	380
Number of phone calls made	800
Number of patients who declined community services	14
Number of patients with a follow up face to face contact by a clinician	272
Number of patients with follow up telephone calls by clinicians	234
Number of referrals to community services	98 (26%)
Number of referrals to voluntary services	3
Number of patients currently active with community services when contacted	54
Number of patients seen by community admission avoidance team	21 (5.5%)

5.3 Qualitative data from interviewing clinical staff from acute wards has indicated that there is significant confusion regarding the services offered within the community and in particular how to refer patients. This is substantiated by the data from the 48 hour

pathway. It is therefore imperative that a clear, uncomplicated pathway is developed and communicated across the Trust and to local partners such as GPs in order to maximise referrals and reduce the number of patients with unmet needs. In addition to the 48 hour pathway rollout, it is suggested that all community services will be accessed by 1 single point of access contact number. Administrators and where required clinical staff will undertake triage and assessment of need before arranging appropriate community support. This will also include voluntary and 3rd sector services.

5.4 The Trust currently reports **readmissions within 30 days** as 8.4% with the objective to reduce this to 7.4%. Streamlined pathways between acute and community services are a vital part of achieving this. In addition to the general referral pathway to community, additional focused work is required to improve pathways for specific specialities. For example it has been identified that there is a lack of cohesion within the acute and community respiratory pathway. This is further confounded by recent 30 day readmission data that show the Trust comparing unfavourably to peer group for patients with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) with lower respiratory tract infection.

5.5 It is suggested that focused work is undertaken by PCCT in partnership with the acute teams to redesign the respiratory pathway with the objective of increasing patient satisfaction, reducing readmissions and reducing length of stay. It is intended that successful redesign will then be applied to other pathways. The proposed redesign will include an in-reach model where community staff will review patients on acute wards to facilitate discharge. The in-reach model will maximise referrals to the Outpatient antimicrobial team (OPAT) for intravenous antibiotics, spirometry and community wrap around services for holistic needs. In addition analysis of high intensity users and collaborative working with GPs with strengthened MDT contribution will aim to reduce admissions. Alongside this pathway redesign it is imperative that ED staff and the ambulance service have direct access to the community admission avoidance particularly for uncomplicated exacerbation of COPD and chest infection.

6. Summary of proposed actions to improve access to community services

Objective	Action	Outcome measure	Timescale
All patients receive equitable access to community services	Improve data validity regarding demographic information	98% of patients on the community caseload will have ethnicity, religion and language recorded	March 2020
	Patients with sensory or learning disabilities will be identified and recorded	98% of patients with a disability will have this information recorded	March 2020
	Redesign the pathway between adult community and mental health services	All patients with unstable / deterioration to mental health will have an individualised care plan with support from mental health services where required	September 2020

Objective	Action	Outcome measure	Timescale
	Further exploration of specific community services (District Nursing) where the caseload does not represent the local community	Increase the number of people from underrepresented groups by 1%	
	Undertake an audit to establish if outcome measures (quality of life, mortality) differ for patients from different backgrounds.	Audit complete and presented. If statistically significant differences are identified between groups, devise a long term strategy to tackles inequalities	September 2020
	Undertake a mapping exercise to identify gaps in Trust and community relationships and corresponding underrepresented patients on the community caseload	Complete community and 3rd sector gap analysis and develop links with underrepresented groups	December 2020
	Strengthen patient and public involvement in service redesign	All community services to evidence patient and public involvement in service design and evaluation	June 2020
Ensure patients discharged from acute wards receive the required community care	Full rollout of the 48 hour pathway	All adult patients discharged from acute wards in the Trust to receive a follow up phone call within 48 hours	December 2019
	Streamline the referral process from acute to community care by developing a single point of access community contact number	95% of acute staff and GP colleagues to understand the referral process into community services	March 2020
	Redesign the respiratory pathway between acute and community services	Reduce Trust readmissions within 30 days due to chronic respiratory disease by 1%	September 2020

7. Recommendations

7.1 The Trust Board is asked to:

a. Discuss the current composition of the community caseload in comparison to the local population demographics
b. Note current pathways between acute and community care
c. Discuss proposed objectives to improve access to services

Tammy Davies
Group Director, Primary Care, Community and Therapies

July 2019