Paper ref:	TB (05/22) 017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title:	Place Based partnership Update		
Sponsoring Executive:	Daren Fradgley, Chief integration officer		
Report Author:	Tammy Davies, Group Director of Primary care, Community & Therapies		
Meeting:	Trust Board (Public)	Date	4th May 2022

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

The paper narrates the progress of the Sandwell Health and Care Partnership to date with an outline provided of the 5 key work streams which were endorsed by the partnership Board in April. The work streams are largely representative of those initially planned by the partnership with the notable addition of 'general practice' which has been included as an additional focus point. Although it is acknowledged that general practice is integral to the other work streams, a decision was made to include it separately to ensure adequate resource is targeted on improving sustainability and delivery of the PCN contracts to support local communities.

It is the intention of the partnership to include family safeguarding in the town teams work stream. This is intended to enable a shared resource to support delivery of the forthcoming Liberty Protection safeguard (LPS) and improve proactive safeguarding strategies.

An overview of the partnership's strategy to support the urgent care agenda is provided with a focus on working collaboratively with other Places to divert category 3 ambulance calls. This model, supported by the development of the Care Navigation Centre, will reduce ED attendances with increased activity in both urgent community response and virtual wards.

The progress in Ladywood & Perry Barr (West Birmingham "Place") is described including the strategy planned in the area to meet the agreed priorities through an agreed work plan. It is anticipated that this will support the pathway development essential to the MMUH opening programme.

2.	Alignment to our Vision *[indicate with an 'X' which Strategic Objective this paper supports]*				
Our Patients		Our People		Our Population	
To be good or outstanding in everything that we do		To cultivate and sustain happy, productive and engaged staff		To work seamlessly with our partners to improve lives	x

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

4.	Recommendation(s)
The Trust Board is asked to:	
a.	**DISCUSS** the Sandwell operating model and in particular the addition of general practice as a separate work stream
b.	**NOTE** the work being undertaken in collaboration with Walsall to support safer urgent care

	provision
c.	**NOTE** the progress in Ladywood & Perry Barr
d.	

5.	**Impact** *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*							
Trust Risk Register Number(s)								
Board Assurance Framework	x							
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: 4th May 2022

Place Based Partnership update

1. Introduction

1.1 As the strategic direction of integrated care systems (ICS) begins to take shape, the local development of place partnerships is forging ahead. In Sandwell the maturity of the partnership is evident, and the delivery model endorsed by the partnership Board is now providing clear operational structure.

1.2 Acknowledgment of the benefits of working with other Places whilst maintaining the required level of independence to support the local population is central to the effort to improve urgent care pathways. The collaboration with Walsall to divert ambulance category 3 calls into community pathways is a clear example of this which will be described in the paper.

1.3 In Ladywood & Perry Barr it is acknowledged that a focussed work plan to meet the agreed priorities at pace is required with quarterly oversight. The work in this area to strengthen our partnership with GPs and community providers has continued with alignment to deliver the MMUH opening programme as well as reduce inequalities

2. The Sandwell health and care partnership: operating model

2.1 Following on-going consultation and consideration, the partnership has further adapted the **operating model** which will provide the framework for meeting the agreed objectives. The work streams (annex 1) previously presented (resilient communities, town teams, intermediate care and care navigation) will remain alongside an additional section; general practice.

2.2 Previous analysis had determined that **general practice** would be incorporated into the original 4 work streams rather than be a separate entity. However, discussion with local GPs and across the partnership highlighted the requirement for additional resource and focused effort to improve the current position which would ultimately affect the local community.

2.3 The 8 Primary Care Networks (PCNs) across Sandwell are variable in regard to performance and future work force sustainability but all have been greatly affected by the pandemic and are seeing an unmet need within their local area. The impact of this both in regard to population outcomes and the bearing on urgent care provision is evident and likely to progress without a concerted effort and a change in delivery.

2.4 An improvement programme being delivered in partnership with Sandwell GPs has commenced with a focus on refining the pathways between primary and secondary care. A total of 5 general engagement events were hosted and attended by the PCN clinical directors, secondary care clinicians and operational teams. The events highlighted several areas for change including the function of the Trust Single Point of Access (SPA), the Advice and Guidance process and clinical communication. We are now

embarking on a programme of practical workshops with measurable outcomes to address the practical issues.

2.5 The **Additional Roles Reimbursement Scheme** (ARRS) designed to create resilience in general practice with a holistic workforce to deliver the primary care directed enhanced service (DES), has been extended with additional income for recruitment. SWBT has made an offer to all PCNs to recruit and host the additional roles. The offer is intended to increase the likelihood of recruitment and enable a network of professionals with a more sustainable workforce to deliver the DES and support the partnership model.

2.6 In addition to the 5 main work streams, the operating model, endorsed by the partnership board, is explicit in highlighting delivery in several sub-categories to ensure focus is maintained in areas of greatest need. This includes children and young people, mental health and safeguarding as well as enablers such as estates, digital, workforce and communications. **The 5 main work streams and additional focus areas are presented in annex 1**.

2.7 As well as featuring as an additional area of focus, the partnership has recommended that the delivery of **family safeguarding** will be included in the town teams work stream. It is proposed that the delivery of the upcoming **Liberty Protection Safeguards** (LPS) will be more successful both in terms of additional resource required and the ability to share information if safeguarding is undertaken within town teams. In addition, it will support a proactive safeguarding model where high risk and vulnerable individuals and families can be recognised and supported by health, social care, 3rd sector and other organisations such as education providers. The proposal is supported by the Sandwell Adult Safeguarding Board following a number of serious reviews where lack of joined up working and communication were sighted as contributory factors.

2.8 It is recommended that safeguarding delivery will sit within town teams but with specialist safeguarding staff continuing to have a presence on the acute sites with oversight and accountability from the Trust's Chief Nurse. The teams will be organised to ensure statutory responsibility within the Trust is delivered in addition to a more cohesive community offer. The risk of supporting this proposal is minimal as all required safeguarding commitments will continue to be delivered and assurance will be gained from on-going monitoring and audit.

2.9 The agreed operating model has been designed to support the delivery of the **population health outcome measures**. The first draft of the agree measures which are being coordinating by the director of public health are presented for noting in **annex 2.** A few additional items are being added to this set, but the draft shown in the paper is approved by the Place Board and the final version will go for full approval and build on this version 17th May 2022. A dashboard is being created off the back of these approved measures and presented Bi annually.

3. Urgent care and out of hospital priorities

3.1 The delivery of the **urgent community response** service (UCR2) within 2 hours of referral has continued to exceed the national target of 76%. However, it is acknowledged that the number of appropriate calls remains low and more work is required to maximise usage. This will be achieved by the development of the combined **care navigation centre (CNC)** where all GP referrals will be considered for community response.

3.2 The success of all urgent community care pathways will be influenced by the establishment of the CNC which will provide a coordination function for all citizens requiring support either on discharge or presentation. The CNC will create a community first approach to avoid ED attendance and expedite discharge. The demand and capacity driven approach will make full use of virtual wards and urgent community response as well as the Discharge to assess (D2A) function. The planned CNC model is the first example nationally of a coordination centre bringing together health and care services in a control centre format to ensure citizens have access to the right service at the right time. With the inclusion of direct access into urgent community pathways, specialist services, social care and 3rd sector support, access across the locality will be coordinated and resources will be directed as required. Stage 1 of the CNC model which involves combining current access points will be complete by the end of May 2022 .

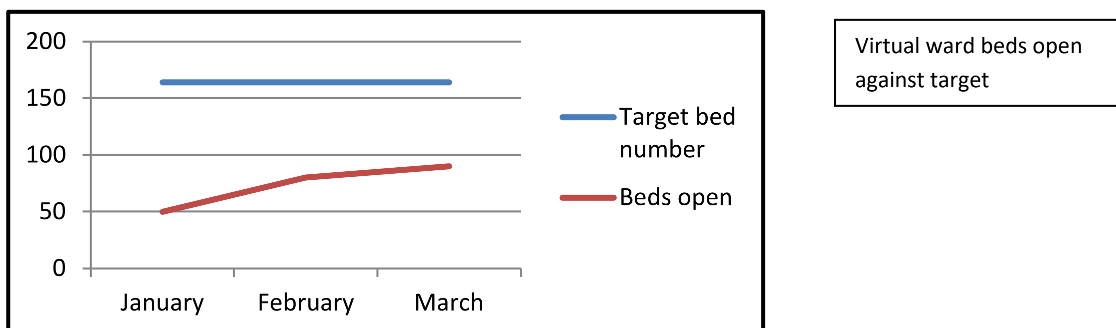
3.3 The volume of calls to the ambulance service continues to be unprecedented both within Sandwell and across the ICS. The partnership's ambition to take the majority of category 3 calls from the ambulance service and into community urgent response will be further established over the next 3 months and will further drive down actual conveyance rates to our Emergency Departments.

3.4 In order to strengthen delivery, Sandwell Place is working collaboratively with Walsall to develop a shared model to increase the transfer of cat 3 calls into community services. A shared rota is being established to ensure clinical presence from 1 of the localities within the **West Midlands Ambulance Service (WMAS)** control centre. This will enable a consistent and sustainable approach with shared resource. A trusted assessor model will be established with the allocated clinician having knowledge of the community services available in each area.

3.5 The **triage collaboration model** is being discussed across the ICS with a recommendation that all 4 Places participate in future delivery. This will maximise the impact on overall urgent care pathways.

3.6 The **virtual ward** offer is progressing with a total of 90 beds now provided which is 55% of the total required of us by the national planning guidance by April 2023 and plans are in place to achieve full compliance by September 2022. The acute hospital virtual ward is currently operating solely in Sandwell due to the provision of community services by the Trust in this area. Over the next 6 weeks pathways with Birmingham Community Healthcare NHS Foundation Trust will be established to ensure equal provision for

residents of Ladywood and Perry Barr. This will reduce inequalities and increase overall virtual bed occupancy.



4. Ladywood & Perry Barr (West Birmingham Place)

4.1 Ladywood and Perry Barr are developing a **locality based model** in line with the wider Birmingham and Solihull (BSOL) system. The key priorities were agreed at the West Birmingham ICP in March and a subsequent work programme has been created for quarter 1 of the year. The work programme will operate a ‘sprint model’ to achieve progress at pace

4.2 The proposed work plan includes focus on MMUH pathway alignment and engagement with GPs and community providers to achieve seamless provision and reduce inequalities.

4.3 **GPs in West Birmingham** are progressing with their plans to develop a ‘single voice’ through a partnership agreement with SWBT. This will enable a sustainable function through which the MMUH opening programme can be delivered.

4.4 Disease specific pathways continue to be developed between the Trust and West Birmingham GPs utilising **population health data** to improve outcomes for the local community. In addition to the work undertaken to improve diabetes care, pathways arounds respiratory disease and breast cancer are being developed in partnership.

4.5 A number of outreach projects with the local community in West Birmingham are being undertaken specifically linked to improving access to services for school aged children. The Trust’s Heath street practice is leading work with local schools to improve health choices and reduce inequalities

5. Recommendations

5.1 The Trust Board is asked to:

a. **DISCUSS** the Sandwell operating model and in particular the addition of general practice as a separate work stream

b. **NOTE** the work being undertaken in collaboration with Walsall to support urgent care provision
c. **NOTE** the progress in West Birmingham

Tammy Davies
Group Director
Primary care, Community and Therapies

April 2022
Annex 1: Outline of agreed work streams for Sandwell operating model
Annex 2: First draft of agreed outcome measures

Paper ref:	TB (05/22) 017

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Annex 1 - Main work streams

Resilient Communities

- Drug Harm Reduction
- Alcohol Harm Reduction
- Smoking Cessation
- Weight Management and Physical Activity
- Children's Health and Education
- Housing and Environment
- Social Isolation and Community Development

Primary Care

- PCN DES Oversight & Delivery
- Demand Management
- Workforce Planning
- Restoration, Recovery & Re-imagination
- Pathway development
- Investigations
- Data / Business Intelligence
- Primary & Secondary Care Interface
- Mental Health

Integrated Town Teams

- Co location of teams
- Single leadership structure
- Alignment of known resources inc accommodation options
- Coordination of activity
  - Demand and capacity MDT's
  - Generic complex MDT's
- Family Safeguarding
- Care home in reach and management
- Step Down support
- Single referral processes – two way
- proactively supports high risk citizen supported by the use of population health data
- Develop shared data and records

Intermediate Care

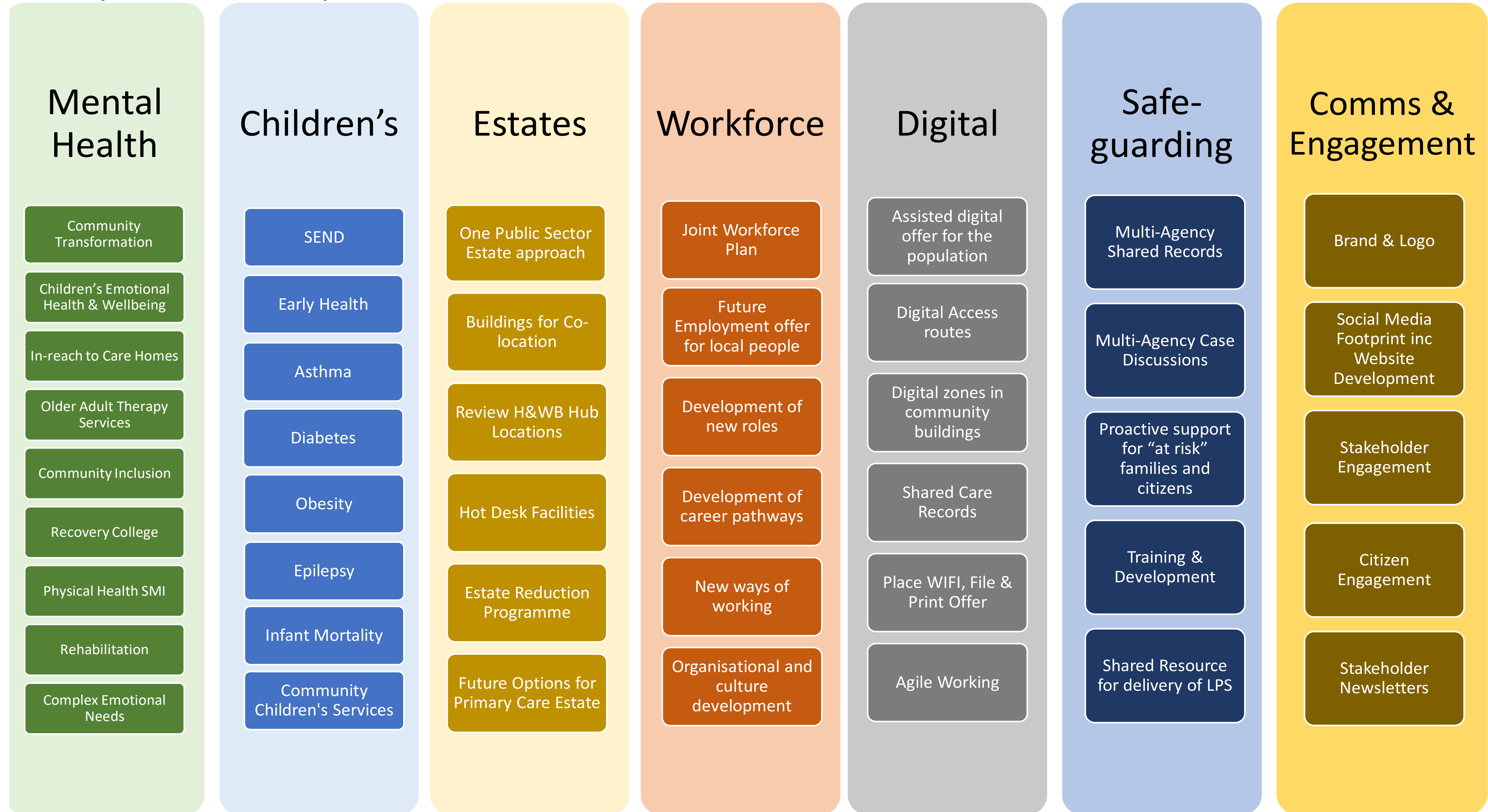
- Step Up / Step Down / Rehabilitation
- DTA: Pathways 1 – 4
- STAR Review
- Single Handed Care
- Digital
- Intermediate care provision – Harvest View
- Rowley and Leasowe beds
- 2 Hour Response
- Mental Health
- Integrated Discharge Hub

Care Navigation

- Virtual wards
- Single navigation function for
  - Professionals
  - 999 / 111
  - Known service users
- Virtual complex case management
- Central demand and capacity overview
- Ops centre
- Advice and guidance for remote professionals
- Virtual multi disciplinary teams
- Mental Health

Cross Cutting: Mental Health / Children's / Estates / Digital / Safe Guarding / Workforce

Secondary work streams / focus points



Annex 2- **Sandwell health and care partnership outcome measures: 1st approved draft**

Organisation	Outcome	AGE GROU
ASC	Further promotion of 'Home First' to support people to promote independent living at home	A
ASC	Workforce strategy	A
ASC	Asset/ strength- based practice	A
ASC	Having a strong community offer that improves and supports prevention	A
ASC	Managing the market to ensure customers have a choice of quality and addordable providers to meet their care and support needs	A
BCP	Estimated diagnosis rate for people with dementia	A
BCP	Dementia care plan reviews	A
BCP	People with severe mental illness (SMI) receiving a full annual physical health check (PHC)	A
BCP	Learning disability registers and annual health checks delivered by GPs	A
CH	CYP SEND, Mental Health and Wellbeing	Y
CH	Early help- early intervention and prevention aligined to family hubs model	Y
CH	CYP Educational attainment inc. a focus on NEET for care leavers (19+) and Early Years, language development a step on from EYTA work	Y
CH	The youth offer aligned with wider regernation opportunities to include employment and skills alongside apprecticeships	Y
CH	Preparation for adulthood - supporting the transitions between children and adults	Y
CH	Domestic abuse- children, victims and perpetrators	Y
PH	Reduce Smoking Related Harm	A
PH	Reduce Alcohol Related Harm	A
PH	Reduce Drug Related Harm	A
PH	Reduce Obesity Related Harm	A
PH	Public Health Support to Infants	Y
PH	Public Health Support to the Voluntary Sector	A&Y
SCVO	Strong and responsive voluntary and community sector	A&Y
SCVO	Making a different where it's needed by making the most of what Sandwell has	A&Y
SCVO	Enabling access to support for all Sandwell Residents	A&Y
SWBH	Reduce the total number of hospital bed days for people aged 65 and over	A
SWBH	% of people achieving their prefered place of death	A
SWBH	Improve the survival rates for people with a cancer diagnosis	A
SWBH	Number of urgent (unplanned) readmissions to hospotal within 30 days of discharge and benchmark against regional and national data	A
SWBH	Improve the outcomes for children and young people - best start	Y
PC	Improve the diagnosis of patients with hypertension by 1.2% from current baseline	A
PC	95% of all children will have received vaccinations as per the National childhood immunisation schedule as appropriate to their age.	Y
PC	90% of patient eligible for influenza and pneumococcal immunisations will have received their vaccinations	A
PC	All care home residents will have a personalised care and support plans agreed or reviewed at least annually at a MDT.	A
PC	80% of all women have had screening for cervical cancer within the last 3 years if aged between 25-49 years and last 5 years if aged between 50-64 years	A

AGE GROUP: A - Mostly focused on adults; Y – Mostly focused on C&YP; A&Y – Mostly focused on whole community development