Paper ref:	TB (10/22) 007

PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Place Based Partnership Update		
SPONSORING EXECUTIVE:	Daren Fradgley, Chief Integration Officer		
REPORT AUTHOR:	Tammy Davies, Group Director PCCT		
MEETING:	Public Trust Board	DATE:	5th October 2022

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

Place Based Partnerships are focussed on 2 main objectives:

- Improving the lives of local people by reducing inequalities
- Creating an integrated approach to health and care that will improve efficiency and effectiveness of delivery

Improving lives and reducing inequalities is not going to be achieved quickly. Nevertheless, if we don't concentrate on moving the dial in this area, whilst acknowledging that instant results won't be achieved, we will be forever firefighting and dealing with unmet need. The unprecedented and growing demand on our urgent care services requires more rapid improvement and it is through the efficiency gains of an integrated offer and strengthening community provision that this will be achieved. The role of Place Based Partnerships is to concentrate on both areas, working towards a sustainable solution for the community and our services.

The report provides an overview of our partnership plans to tackle inequalities via a citizen centred approach, delivered across our work streams. In addition, progress in supporting urgent care demand through reduction in attendance, admissions and length of stay is presented

2. Alignment to our Vision *[indicate with an 'X' which Strategic Objective[s] this paper supports]*

OUR PATIENTS		OUR PEOPLE		OUR POPULATION	
To be good or outstanding in everything that we do	X	To cultivate and sustain happy, productive and engaged staff		To work seamlessly with our partners to improve lives	X

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**NOTE** the progress within Place Based Partnerships
b.	**DISCUSS** the impact of the Place developments on urgent care demand

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

Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*

Board Assurance Framework Risk 02		*Make best strategic use of its resources*					
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*					
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*					
Board Assurance Framework Risk 05	x	*Deliver on its ambitions as an integrated care organisation*					
Corporate Risk Register [Safeguard Risk Nos]							
Equality Impact Assessment	Is this required?		Y		N	If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 5th October 2022

Place Based Partnership Update

1. Introduction

1.1 Successful delivery of our local Place Based Partnerships is vital in order to reduce demand on hospital urgent care pathways both in the short, medium and long term. Strengthening community services through multi-agency integration will enable more people to be appropriately managed in the community, enabling acute hospital care to be available for those most in need.

1.2 It is imperative that we succeed in this area, both to improve patient care, experience and safety and to enable the successful delivery of MMUH. The acute and community care models are designed not to enable our patients to 'fit' into a new hospital bed base but because they provide an opportunity for more people to achieve high quality, effective care when and where required. The Place based Partnership must deliver objectives in order to realise the benefits.

1.3 Through engagement with local people we know that current systems and processes are inadequate and deter from a person-centred approach. Linked to our **Fundamentals of Care** framework, our partnerships are working to deliver a model that enables people to be at the centre of a coordinated approach to care. For this to be truly effective we require all agencies from primary care through to acute hospital services and inclusive of social and voluntary providers to work as one seamless team.

1.4 As we work at pace to reduce urgent care demand, we must also focus on a long term sustainable solution to tackling inequalities. This must be undertaken in a holistic, multi-faceted approach to achieve better future outcomes for our community

2. Reducing urgent care demand

2.1 The current volume of unplanned urgent care attendance is unprecedented and unsustainable.

2.2 The **Care Navigation Centre (CNC)** is now operational, taking approximately 52k calls per month from clinicians and the public. The CNC provides clinical triage with direct access to urgent community pathways, 3rd sector support and general advice. Operating a postcode blind 'no wrong door' approach, **CNC aims to avoid ED attendance** where possible.

2.3 CNC has direct access to the West Midlands Ambulance (WMAS) caseloads and takes patients directly into community urgent care where possible. This linkage is now becoming critical as we form a relationship between urgent care disruption and working with WMAS to better managing patients that access 999.

2.4 **Urgent Community Response (UCR2)** is likely to be the biggest disrupter to hospital based urgent care pathways. Currently we are achieving the 2 hour target of 70% of suitable patients seen within 2 hours. However, the total numbers remain low and so as yet there is little impact on ED attendance. Figure 1 shows the referral source and although at 20%, referrals from WMAS are higher than the 7% across seen the Black Country system, there is substantial opportunity for growth

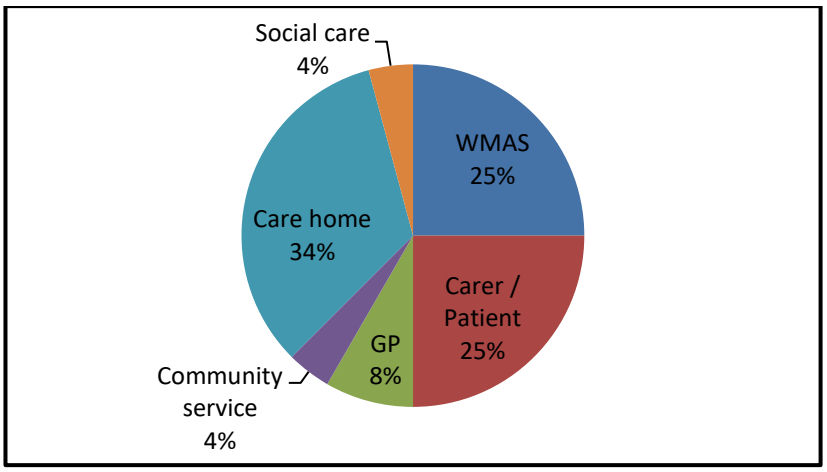

Figure 1: UCR2 Referral source by %

2.5 Closer working with neighbouring Places is required to increase numbers by enabling WMAS to have 1 consistent referral route. We are working with Walsall to share resources and processes in this area with the intention to also engage with Wolverhampton and Dudley

2.6 The total numbers of people managed in **community admission avoidance** services has increased considerably when all people with urgent needs are appropriately directed into a rapid response service. As discussed in previous months, the process of getting more and more of these services within a 2 hour response is material if we are to provide timely, person centred care that prevents the need for attendance to ED which is often seen as a last and more timely resort.

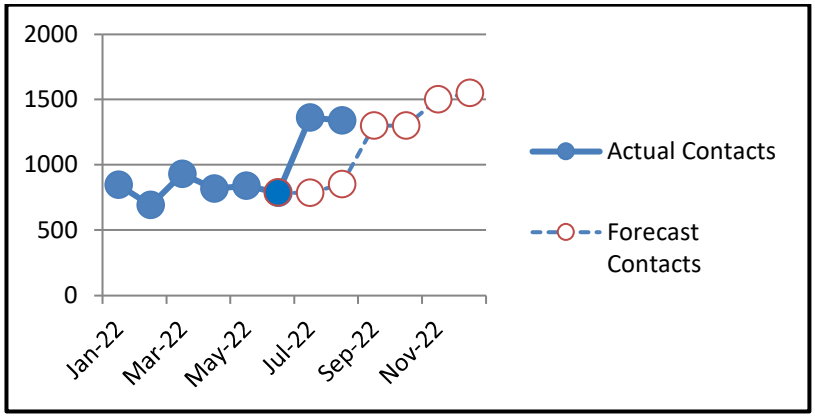

Figure 2: Number of people reviewed in community admission avoidance services (same day review

2.7 Data shows that there are high volumes of people sustaining **falls at home** without serious injury. Such people often wait for unacceptable lengths of time because of WMAS demand, leading to poor experience, deterioration of condition and subsequent higher likelihood of hospital admission.

2.8 Community investment funding has been approved to commence recruiting to both the falls service and the **Integrated Front Door (IFD)** service. IFD will provide a route to triage and redirect patients attending ED directly into community pathways. Benchmarking against areas that have utilised a similar model has shown substantial potential for admission avoidance (figure 3) with a predicted 450 patients per month. This model is based on deployment protocols that are in place in other areas of the country.

Figure 3: *Trajectory of IFD activity*

Month	December 22	January 23	February 23	March 23	April 23	May 23
Number of patients diverted to community care	232	278	389	465	465	465

2.9 The development of **Virtual Wards** provides potential for significant reduction in hospital length of stay. However, realisation of benefits relies on maximising capacity. This will require significant engagement with acute clinicians to ensure that virtual beds are used for patients that would otherwise have required an extension to their acute hospital admission and not merely as additional monitoring for people who would have been discharged regardless of the existence of the virtual ward. By April 2023 201 virtual ward beds will be available (figure 4)

Figure 4*: Trajectory of virtual ward beds from September 22 – April 23*

	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Heart Failure		10	20	30	30	30	30	58
Respiratory		20	28	28	28	35	35	41
Frailty			22	25	25	40	40	45
Palliative		6	11	17	19	23	23	23
Paeds	5	10	10	24	24	24	24	34
Total	**25**	**41**	**61**	**84**	**86**	**110**	**110**	**201**

2.10 The Virtual Ward beds described are the total across Sandwell and West Birmingham. It is imperative that we maintain a 'post code blind' approach to delivery in this area to remove barriers to referral and increase clinician confidence. A separate delivery model for Ladywood and Perry Barr residents would deter increase complexity and inequalities.

2.11 The **Integrated Discharge Hub** continues to deliver length of stay reduction across complex pathways with favourable data compared to neighbouring Trusts. However, the ambition to further reduce length of stay following the decision that someone can safely be discharged ('no criteria to reside') remains a priority. This will not only lead to significant bed day savings but will also improve the outcomes and experience of our patients. Extended, unnecessary hospital admissions have a dramatic impact on quality of life and therefore a cultural, mind-set change that views prolonged hospital admissions as a risk to safety rather than the risk coming from discharge must be adopted

2.12 One of the significant developments that the partnership is deploying is that of **Harvest View Intermediate Care Facility** This facility is now built and will open to residents **1st November 2022** ready for winter initially with 80 enhanced assessment beds. This facility which brings together health and care professionals into a single building, will ensure that the complex needs of patients being discharged are aligned with the services that are provided by the partnership. This site will also allow the Trust therapists to work alongside social care therapists in a single service benefiting the population we serve.

2.13 Despite significant increase in community provision and the development of integrated services, we are currently not **reducing total bed days for people over the age of 65**. Our local people are more likely to suffer frailty earlier in their lives compared to other areas. If frail older people attend our hospitals, it is extremely likely that they will suffer functional decline, poor outcomes and prolonged admissions. A proactive, multi-agency response is vital to result in positive change. Our Town Teams model in partnership with PCNs are commencing complex MDTs for people with high frailty scores and those in care homes. In addition we are working with the voluntary sector to support people with low / moderate frailty scores to limit functional decline. Alongside our **Frailty Intervention Teams** and virtual wards, this multi-faceted approach will reduce reliance on admission for those with frailty

3. Town teams: reducing health inequalities

3.1 Population health data analysis across health, public health and social care has shown significant inequalities across the different neighbourhoods with **West Bromwich residents having significantly worse outcomes**.

3.2 As part of the Town Teams work stream measures to tackle inequalities have commenced. Working with Health Watch we are engaging with local people through **citizen forums** to co-produce services. The first forum is planned in November and will take place across all towns

3.3 As part of the **Additional Roles Reimbursement scheme**, we are working in partnership with PCNs to recruit **social prescribers** to provide support to people with chronic illness, people who frequently access services and groups of people within the area who are not accessing services (including new and emerging communities). We will also trial our first shared **citizen 'at risk register'** utilising intelligence from all partners to enable the team to direct care proactively

3.4 People living in Sandwell have a much higher likelihood of developing **diabetes** and requiring hospital admission because of inadequate glycaemic control. Within our Heath street practice in Winson Green a targeted, population health approach to diabetes care supported by the specialist diabetes team produced favourable results. This approach will now be utilised for PCNs in West Bromwich

3.5 With local authority colleagues we plan to deliver health care to the local community by delivering health checks and MSK physio interventions in local leisure facilities.

3.6 We will continue to monitor the health and wellbeing of people as our Town Teams model develops to ensure predicted improvements are made.

4. Recommendations

4.1 The Public Trust Board is asked to:

a. **NOTE** the progress within Place Based Partnerships
b. **DISCUSS** the impact of the Place developments on urgent care demand and inequalities

Tammy Davies
Group Director, PCCT

September 2022