Paper ref:	TB Public (09/23) 009

REPORT TITLE:	Place Based Partnership Update		
SPONSORING EXECUTIVE:	Daren Fradgley, Managing Director / Deputy Chief Executive Officer		
REPORT AUTHOR:	Tammy Davies, Deputy Chief Integration Officer		
MEETING:	Public Trust Board	**DATE:**	13th September 2023

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

The following report provides an update on the progress of the Sandwell Health and Care Partnership (SHCP) including the on-going work in readiness for delegated accountability from the Integrated Care Board in April 2024. The maturity of the partnership has resulted in all partners now signing the Place Alliance Agreement.

The performance of both SHCP and the Ladywood and Perry Barr locality is imperative in achieving our winter plan and the Trust rightsizing strategy. Significant progress has been made in this area, supporting delivery of safe urgent and emergency care.

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		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?]*

None

4. Recommendation(s)

The Public Trust Board is asked to:

a. **NOTE** and **DISCUSS** the progress of both Sandwell Place and Ladywood and Perry Barr locality

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		*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	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 13th September 2023

Place Based Partnership Update

1. Introduction

1.1 The future of our Place Based Partnership in Sandwell is set to gain further autonomy by April 2024 with the Integrated Care Board (ICB) in the Black Country supporting the future delegation of accountability. In readiness for the transfer, we have further progressed our governance structure with partners. We are now working with the ICB to demonstrate our ability to deliver through the proposed accountability structure. This has involved outlining our future ambitions with a strategy and timetable to achieve our objectives. The progress of this work and the plan moving forward is sighted in the work of the Integration Committee.

1.2 Within Birmingham, the direction for smaller localities such as Ladywood and Perry Barr within the larger Birmingham Place remains focussed on the development of Integrated Neighbourhood Teams. In addition, we continue to progress our partnership with local GPs in the area which is complimented by the emerging Birmingham and Solihull (BSOL) ICB General Practice strategy.

1.3 The progress within both Sandwell and Ladywood and Perry Barr is having a positive impact on our rightsizing work towards MMUH and the successful delivery of our winter plan. In order to achieve both, the continued delivery through Place and Out of Hospital services is paramount.

1.4 The report outlines the position and developments across both Sandwell Place and the Ladywood and Perry Barr locality.

2. Governance and assurance

2.1 A key part of our governance review in Sandwell is the agreement by all partners to sign an **Alliance Agreement** which sets out the conditions and requirements of all organisations to work together as an integrated partnership. The document also provides a framework for partners to follow according to agreed levels of involvement with the partnership. The table below is incorporated within the agreement. The Alliance Agreement has been approved by the Integration Committee and is based on the successful deployment with Walsall Together.

Table 1: Alliance Agreement levels of involvement

	Agreed Role	Requirements of the organisation
Core members (requires agreement from organisation Board or equivalent)	Corporate accountability to identify, drive and evaluate change Set and oversee strategic direction Contribute to the planning and utilisation of resources	Chair partnership meetings and delivery groups Contribute resources (financial and staff) to integration and service transformation Provide transparent access to performance data Members of Board, SMT and operational management committee supplying appropriate reports and data as required
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

2.2 We are developing a set of **metrics and outcome measures** which will align to the **Trust annual plan** but provide an area of focus for Place performance. This is being supported by a refreshed Joint Strategic Needs Assessment to ensure we are prioritising appropriate areas for Sandwell citizens. To support the delivery of outcome measures we have developed a data dashboard to drive operational performance by all partners. It is important to note that from a Trust perspective, this will focus on **attendance** and **admission avoidance** and **length of stay reduction** initially, but this will not be a universal objective for all partners.

2.3 The reduction in **health inequalities** is an integral component of our ambitions in Sandwell and is a golden thread through all delivery groups. Aligned to the Trust annual plan, we have undertaken a review of diabetes prevalence across all Sandwell towns and in response are developing an integrated strategy to support improvements. The key actions for all delivery groups are summarised below.

Table 1: Delivery Groups actions for diabetes

	Delivery Group	Work stream	Diabetes response
Urgent / Unplanned Care	Intermediate Care	• Intermediate Care • Care Navigation	Specialist diabetes teams supporting admission avoidance & length of stay reduction through the use of Epicentre Virtual Ward
Proactive / Planned Care	Integrated Primary Care	• Town Teams • Primary Care	Targeted and stratified community diabetes support to GPs
Prevention	Prevention & Health Improvement	• Healthy Communities	Education campaign in schools and GP surgeries

Patient story

Mrs Jones is a 79-year-old lady living in a Sandwell Care Home. She has a history of type 2 diabetes and Chronic Heart Failure. In July 2023 she suffered a fall. The Sandwell Care Navigation Centre were contacted and arranged for the Urgent Community Response Falls Service to respond. She was safely lifted from the floor and assessed for injuries and root cause of the fall. She was safely treated and deemed to have not sustained injury requiring ED attendance. She did sustain a skin tear which was dressed by the team. Her blood glucose level was found to be low and on review of her records it was identified that she has frequent episodes of hypoglycaemia (low blood sugar). Her diabetes medication was altered, and the team arranged for tailored and on-going diabetes education for care home staff to support future identification of diabetes issues.

2.4 As part of our preparation for the intended **CQC regulatory changes** where Place Partnerships rather than individual organisations will be inspected, we have developed an integrated quality group. This has enabled us to identify and mitigated specific Place risks. For example, we are currently undertaking a review of tissue viability and infection control support for local care homes following a trend of increased incidents. We have also identified a disparity in palliative care support for children and young people in the area with a planned response. The work of the integrated quality group will have a line of reporting in Quality and Safety Committee..

2.5 The new governance structure includes the addition of a **Collaborative Commissioning Board** which will support the utilisation of financial resource through a prioritisation matrix which will ensure the support of all providers before resources are committed or disestablished. This will include both the Better Care Fund and any future delegated budgets to the wider place partnership.

2.6 Within **Birmingham Place (BSOL)**, the subdivision into localities, including Ladywood and Perry Barr remains the BSOL system strategy. The primary objective for Birmingham is centred on the development of an **Integrated Neighbourhood model** to tackle urgent care demand and reduce inequalities. We have participated in the development of the model which has concluded that through an integrated case management approach, 5% of the population who frequently utilise our services will be impacted with a significant reduction in ED attendances and admissions. Further progress has been made on the leadership model for localities but is not yet ready for formal publication.

2.7 In addition, BSOL are developing an enhanced **General Practice strategy** to support resilience. Within Ladywood and Perry Barr, we are a key stakeholder for this work and concurrently we are progressing cohesive partnership with GPs. We are working with GPs in Ladywood and Perry Barr to develop **community specialist clinics** in prevalent conditions including diabetes, respiratory, cardiac and paediatric care. This will increase collaborative working and support admission avoidance towards winter and MMUH. The Trusts presence at Summerfield is pivotal given this site has been chosen as the locality hub for primary care expansion.

3. Performance and Delivery

3.1 **Unplanned Community Care** delivered by Sandwell Health and Care Partnership, continues to show areas of success with improvements across attendance, admission and length of stay reduction. **Urgent Community Response 2 Hour (UCR2)** has met the national target of 70% of all patients seen 2 hours for the 4th consecutive month, with 85% of all patients remaining in their usual place of residence.

3.2 To impact the demand on acute urgent and emergency care, increasing total UCR contacts is a vital and as such is Trust Annual Plan objective. However, we are not yet meeting the target number of 1500 monthly contacts across all urgent community services. The Intermediate Care delivery group are overseeing an improvement plan that includes restructuring of the team and additional triage support through Care Navigation. Our UCR activity will also be improved through the **confirmed funding from the Better Care Fund (BCF)** to continue and expand the falls response service. This risk has been mitigated since the last report to Trust Board. It is also worth noting that not all urgent community response visits are categorised as 2 hours but if this is case they fall outside of the national performance monitoring.

3.3 We have seen growing success with our **falls response service** with increasing contacts for people who would otherwise have required conveyance to the Emergency Department (ED), and potentially prolonged waits and associated risk of admission with increased lengths of stay. The board will note that as the numbers increase the prevalence of opportunity decreases but the beneficial impact on urgent care still remains highly positive.

Table 3: Monthly falls response patient contacts

	Jan 23	*Feb 23*	*March 23*	*April 23*	*May 23*	*June 23*	*July 23*
Number of falls responded	**30**	**33**	**23**	**80**	***128***	***176***	***181***
Total attendances avoided	**30**	**33**	**23**	**80**	***119***	***162***	***170***

3.4 The **Integrated Discharge Hub** have continued to focus on reducing the total number of patients in acute beds with No Criteria To Reside (NCTR) and to increase the number of discharges within 48 hours. There has been improved performance of timeliness of discharge across all pathways compared to last month. Pathway 1 in particular has seen improvement with continued focus on utilisation of the 72-hour wrap, which provides urgent short term domiciliary care.

Table 4: NCTR discharges per pathways

Pathway	% Discharge within 24 hrs of NCTR (prev month)	% Discharge within 48 hrs of NCTR (prev month)	% Discharge within 5 days of NCTR (prev month)
1	22.49 (22.51)	48.52 (41.26)	83.43 (76.58)
2	6.45 (3.66)	19.35 (13.33)	48.39 (35.00)
3	48.00 (10.53)	56.00 (31.58)	76.00 (42.11)
4	23.53 (10.26)	52.94 (33.33)	85.29 (66.67)

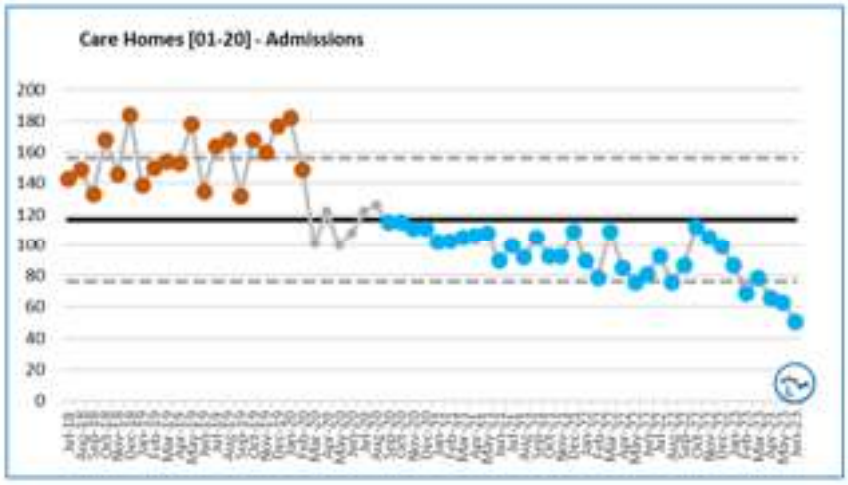
3.5 However, we have seen a specific issue with **delays in people requiring short-term 24-hour rehabilitation or care (Pathway 2)**. The average length of acute hospital stay for people on pathway 2 following being identified as NCTR is 9 days. This provides an opportunity to make significant bed reductions and improve patient outcomes. The partnership in Sandwell have developed an improvement plan to reduce length of stay to 5 days by the end of November 2023.

3.6 The successful delivery of **Virtual Wards** is vital to support urgent care demand through winter and towards MMUH. Despite the funding reduction, we are still on track to provide sufficient capacity to enable the required reduction in acute bed days for frailty and respiratory patients. We are now evaluating the impact of our other virtual wards which are showing benefits for length of stay reduction and the associated benefits ready for winter.

3.7 The **Paediatric Virtual Ward** has seen considerable demand with an average occupancy of 95%. We are seeing high patient and parent satisfaction with low readmission rates. However, the limiting funding is currently preventing further capacity.

3.1 The **enhanced care homes model** in Sandwell has delivered improvements with those homes receiving intensive, targeted care seeing significantly fewer ED attendances and admissions. A proposal of funding options for the dedicated Care homes team is awaiting approval at system level, although it is of note that the full funding allocation is at risk.

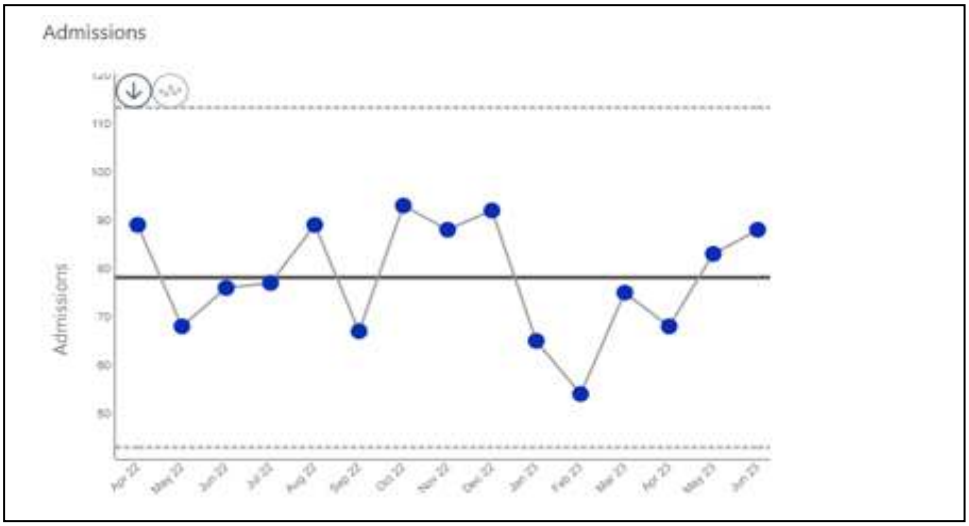
Chart 1: Admissions from Sandwell Care Homes



3.2 The **enhanced Care Homes** support within Birmingham is not as developed as the Sandwell model. We are continuing to track this work and drive performance through the Trust Urgent and Emergency Care Steering Group.

3.3 The chart below shows the inconsistency of admissions from Birmingham Care Homes. To further understand the root cause, we are undertaking case study work to compare to the Sandwell model. However, within Birmingham, Care Homes support is provided as part of the wider Birmingham Community UCR provision rather than a bespoke team.

Chart 2: Admissions from Birmingham Care Homes



3.4 Through clinical triage the **Care Navigation Centre (CNC)** and **Single Point of Access (SPA)** assess and provide interventions for patients avoiding acute admission where appropriate. SPA consistently avoids ED attendances in > 70% of cases. These services are in the process of being integrated.

Table 5: SPA activity

Call Disposition	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Total No of Calls to SPA	1342	1769	2186	2137	2044	1514	1989	1782	2204
Total ED Divert	909	1248	1747	1502	1483	1192	1597	1429	1748
% ED attendance avoidance	68%	71%	80%	70%	73%	79%	80%	80%	79%

Table 6: CNC activity

Call Disposition	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Attendance Avoidance	13336	10199	13162	11968	13233	10813	12721	12765	12298
Admission Avoidance	5825	8096	8782	7826	8692	7432	7635	7635	8023
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

3.5 As our integrated teams become more established, we are undertaking specific reviews of the key **inequalities within towns** with a focus on organising both statutory and voluntary teams to support change. We have now commenced partner multi-disciplinary teams' meetings to discuss high risk citizens and ensure a holistic approach.

3.6 In addition, we have commenced work across the towns to improve access to and delivery of **palliative care provision**. This involves working with PCNs to improve the identification of people within the last 12 months of life. We have commenced the following work streams:

- Primary Care recognition of dying people.
- Education and training
- Compassionate communities and bereavement

3.7 Data is showing a wide disparity in the quality of care and the identification of death and dying dependant on the PCN. We have set appropriate targets to drive performance and support patient outcomes.

3.8 The Integrated Primary Care Delivery Group is overseeing the implementation of recommendations from the **Fuller stocktake review** and undertaking a review of demand and capacity work for Primary Care

4. Recommendations

4.1 The Public Trust Board is asked to:

a. **NOTE** and **DISCUSS** the progress of both Sandwell Place and Ladywood and Perry Barr locality.

Tammy Davies
Deputy Chief Integration Officer
September 2023