Paper ref:	TB (06/22) 011

PATIENTS PEOPLE POPULATION

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:**	8th June 2022

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

This month's Place Based Partnership report describes the impact that successful delivery of the new model will have on patient care and related outcomes. The Sandwell Health and Care Partnership are in the process of transforming local out of hospital care with a model that is ambitious but achievable. As we move towards the opening of MMUH during a time of post pandemic recovery where urgent care, general practice and social care are seeing unprecedented and untenable demand, it is vital that we change our community delivery.

Trust Board are invited to review a patient journey (presented in annex 1) which indicates multiple examples of opportunities to provide earlier, more effective interventions. The case study describes where and how parts of the new model will alter the demand on urgent care, improving access to emergency treatment for those with acute presentations. Further details of each of the 5 work streams, the stage of development and an explanation of how outcomes presented in the case study will be altered, are detailed within the report.

The operational design and delivery is guided by the use of population data. The first iteration of the data relating to each of the 6 Sandwell towns is included in the report with examples of how planned work streams will influence the entire local health system

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** and gain assurance regarding the progress to date
b.	**DISCUSS** the impact the new delivery model will have on patient care and

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	x	*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	x	N		If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y	x	N		If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 8th June 2022

Place Based Partnership update

1. Introduction

1.1 The success of the 2 local Place Based Partnerships (PBP) is fundamental in achieving the aims and objectives of the Trust. The successful delivery of the acute care model and the Midland Metropolitan University Hospital (MMUH) rest on the ability of Place to deliver the planned operating models. Succeeding at Place will ultimately strengthen delivery of community services, reduce demand on urgent care pathways and improve the health and wellbeing of local people. It is therefore, imperative that Trust Board and the wider organisation prioritises the delivery of PBPs; failure in this area will lead to failure in all other key objectives

1.2 This month's report will focus on the progress to date of the Sandwell Health and Care Partnership (the Sandwell PBP). The developments in Ladywood and Perry Barr will be reported in July

2. How the delivery of the PBPs will change patient outcomes

2.1 Annex 1 presents a patient journey that took place in 2021. The actual events experienced by Tom (pseudonym used) are not uncommon and represent multiple examples of how to provide earlier, more effective patient care.

2.2 As presented, at each point of time across the journey, the successful delivery of the PBP work streams would have resulted in an alternative outcome for Tom and his wife. When the model becomes fully operational it will ultimately change the way in which people can access care. In addition, this case alone would have resulted in a saving of 30 acute bed days and 10 community bed days. The partnership's capacity to replicate this across large numbers will equate to a considerable reduction in total beds days. In addition, by altering the urgent care demand curve, access to the Emergency Department (ED) will be smoother and more appropriate for those with acute presentations.

2.3 Perhaps the most thought provoking element, however, is the fact that each point in time (of which there were 10 in total) represents a missed opportunity to improve the life and experience of this individual who ultimately died in an Emergency Department. Delivering the model as planned is a must to prevent similar occurrences.

2.4 The Sandwell Place model is ambitious but on track to be delivered as planned with all elements having associated funding or with agreed routes to funding within the coming year, such as the new financial arrangements for virtual wards. However, it is important to note that additional capacity will require investment in line with actual growth.

3. The Sandwell Health and Care Partnership: progress against work streams

3.1 Each of the 5 work streams are at different stages of maturity with variable availability of data to support evaluation.

3.2 The **Intermediate Care** work stream has the highest level of maturity with significant success in creating the **Integrated Discharge Hub** and delivering the nationally mandated D2A model. The discharge hub is an example of how successful integration translates into improved outcome measures. Health and social care staff, now co-located and working as a single team, have eliminated discharge delays resulting from 'hand offs' between teams. This has resulted in favourable results in May with a reduction in total numbers of people in acute hospital beds deemed ready for discharge (no criteria to reside). In addition there has been a reduced length of stay for people without criteria to reside particularly for those on pathway 1 (home with support) where it has halved from an average of 10.1 days to 5.4 days.

Average # individuals with NCTR

Month	0	1	2	3	4	Total
February	1.2	24.0	12.9	1.1	2.0	41.3
March	1.4	30.5	14.5	3.5	0.8	50.7
April	1.1	27.7	15.2	2.6	1.6	48.3
May	0.5	18.8	11.4	0.8	1.3	32.7

Figure 1: Number of individuals remaining in a hospital bed despite being ready for discharge (NCTR)

3.3 The **UCR2 and total community admission avoidance** services sitting within the intermediate care work stream are continuing to progress in delivery. The national standard for UCR2 is being reached and there is expanded total admission avoidance capacity. The focus of the work stream is now to increase the total caseload numbers and to monitor the patient outcomes to determine quality and effectiveness. In April 2022 80% of patients referred to UCR2 remained at home, 13 % required hospital admission and 7% were stepped up to a community bed. A greater understanding of the origin of the referral is being measured to provide information to drive up referral numbers. The referrals made into the services by GPs are lower than anticipated which requires further analysis and engagement. In addition, trends in referring complaints are being evaluated to inform potential proactive work to prevent future urgent care requirements for certain conditions.

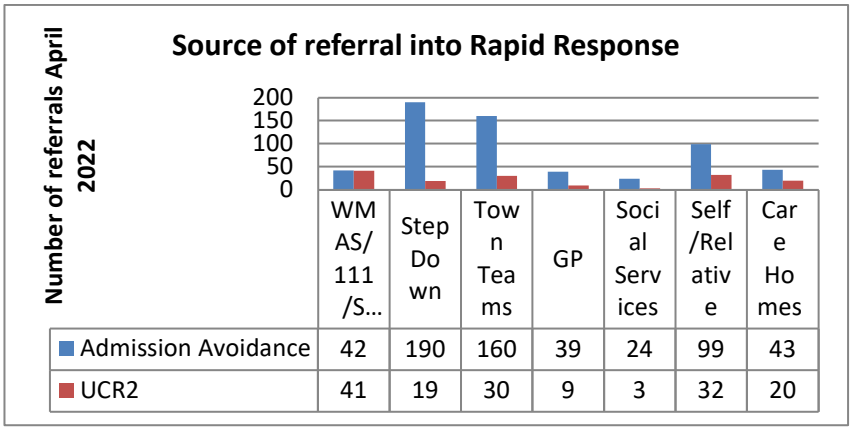

Figure 2: Origin of Admission avoidance and UCR2 referrals

3.4 The **Healthier Communities work** stream led by the Director of Public Health is in the early stages of implementation and will be measured against long term population health outcome measures. The work stream has impressive support from Sandwell's voluntary sector as well as all health and care providers. The aim is to concentrate on initiatives to 'level up' the experience of Sandwell residents where they are less favourable than our neighbours. Figure 3 provides insight into the particular inequalities and wider determinants of health experienced

Figure 3: Health challenges across the Black Country ICS

3.5 The decision to include **primary care** as a bespoke work stream for Sandwell Place rather than as a feature across all other areas is an acknowledgement of the extent to which all parts of the patient journey are reliant on a functioning primary care system. The recent publication of the ***Fuller stocktake report*** supports the work underway in Sandwell by giving credence to priority areas such as creating more joint posts, improving urgent access and utilising a neighbourhood model. The review promotes working differently to sustain a robust primary care model and acknowledges that simply focusing on adding 'like for like', one dimensional general practice is no longer an viable option.

3.6 The primary care work to date has focused on ensuring each Sandwell PCN is resourced to successfully deliver the PCN DES. Funding for Additional Roles Reimbursement Scheme (ARRS) is agreed and will support a challenged GP workforce to deliver appropriate service to their patients by employing other clinical professions (e.g. physiotherapists, paramedics, social prescribers). PCN leaders are facing difficulties in both successfully recruiting to certain positions and also in managing the associated administrative and HR processes. Sandwell Health and Care Partnership are supporting the offer by the Trust to host the recruitment and employment of roles for all PCNs. The benefits in addition to the administrative support for GPs include the ability to provide a robust professional network for individuals with less attrition and a more attractive, competitive offer for recruitment.

3.7 The case study in annex 1 notes the requirement for an earlier GP appointment as the initial intervention that would have influenced a different outcome. The primary care work stream is on track to achieve this by ensuring that PCNs and associated towns teams are resourced and organised to deliver accessible urgent response through a **multi-facetted primary care** team rather than merely increasing GP capacity in its current form.

3.8 The development of the integrated **Town Teams'** model has progressed with dedicated nursing, therapy and adult social care staff now working together in each of the 6 towns. Additional teams and services including mental health, children's services and housing will join the teams over the coming months. The individual neighbourhood teams will address local inequalities as well as responding both proactively and reactively to high risk citizens.

3.9 An initial analysis of town specific data with links to local Primary Care Networks (PCNs) has shown considerable opportunity for intervention. For example there is **wide variation in use of urgent and elective pathways** from residents in different towns following statistical adjustment for population

size. The low SWBT ED attendances in Rowley Regis may be attributed to the close proximity of Russell's hall ED which presents an opportunity for developing strategic pathways with the Dudley Trust, particularly as there is also proportionally lower elective and day case attendances in this area.

3.10 **West Bromwich has significantly higher ED attenders (figure 3)** which arguably may be due to the proximity of Sandwell ED. However, this is not mirrored in Smethwick despite being close to the City site. The Town Teams will now embark on further demographic analysis to understand and react to the variation. The team resourcing and skill mix will reflect the different levels of need in each area to enable a response to reduce unnecessary ED attendances and emergency admissions (figure 6), whilst increasing elective care where appropriate (figure 7).

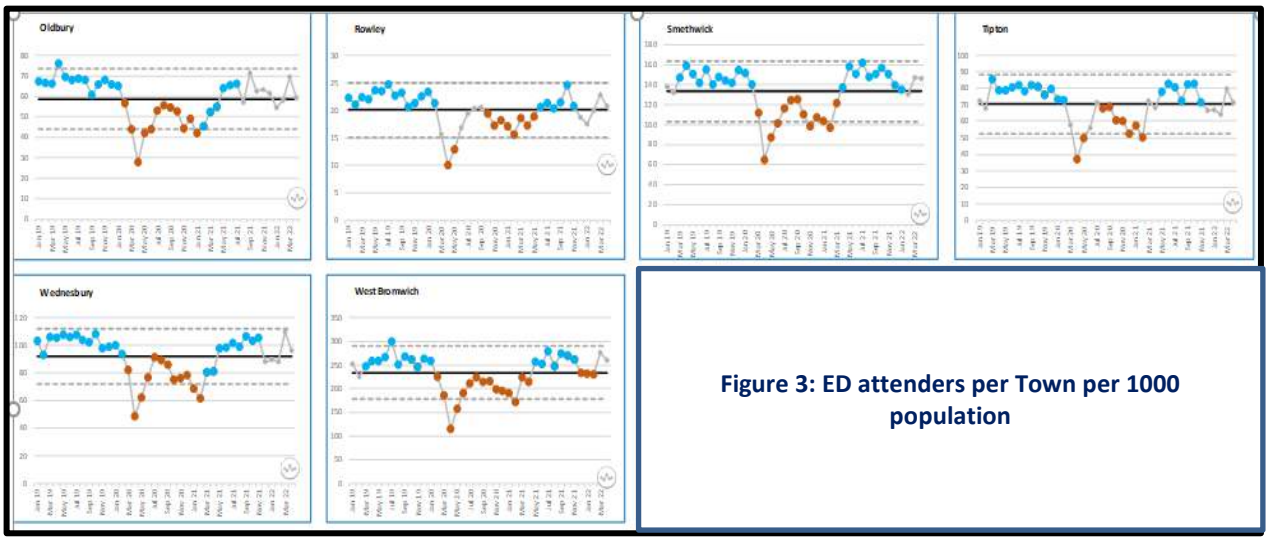

Figure 3: ED attenders per Town per 1000 population

3.11 The **Urgent Treatment Centre (UTC) (figure 4)** attendance numbers are significantly lower across all areas compared to ED attendance. Further analysis of the ED presenting complaint data will enable us to identify areas of opportunity to move activity to UTC.

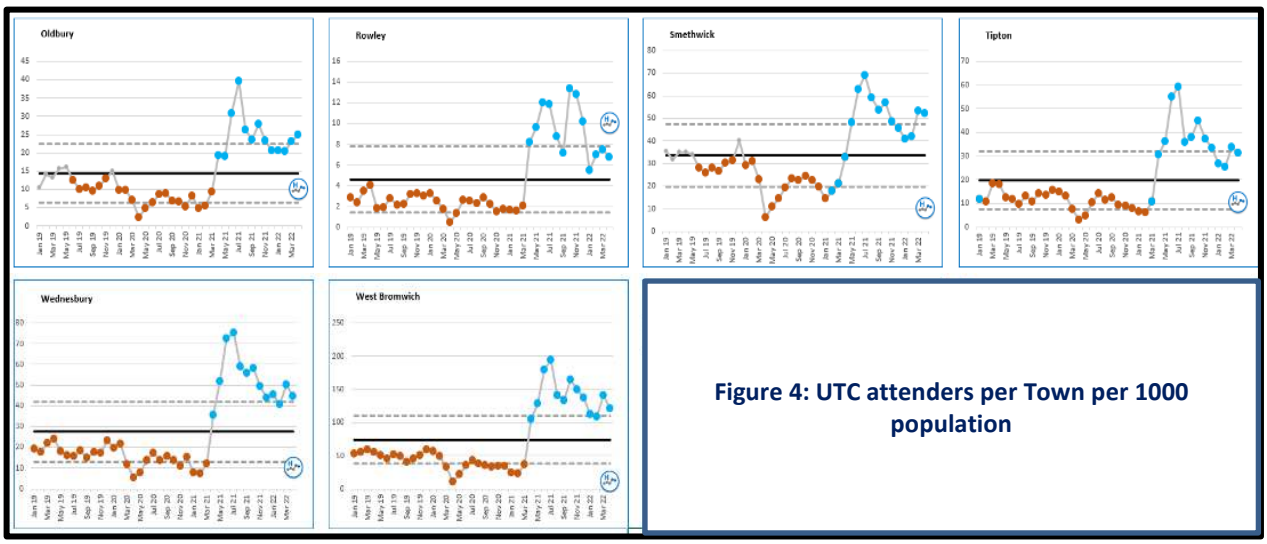

Figure 4: UTC attenders per Town per 1000 population

3.12 In comparison **Day case numbers (figure 5)** are largely stable in most areas although additional work needs to be done in Smethwick to look at the post pandemic recovery albeit the variation is very small. It's also worth noting that the variation between towns is not as high as that seen in

emergency and urgent access showing that different GP practice utilisation could be a factor. The town teams will need to understand this and react appropriately with specialist intervention and engagement

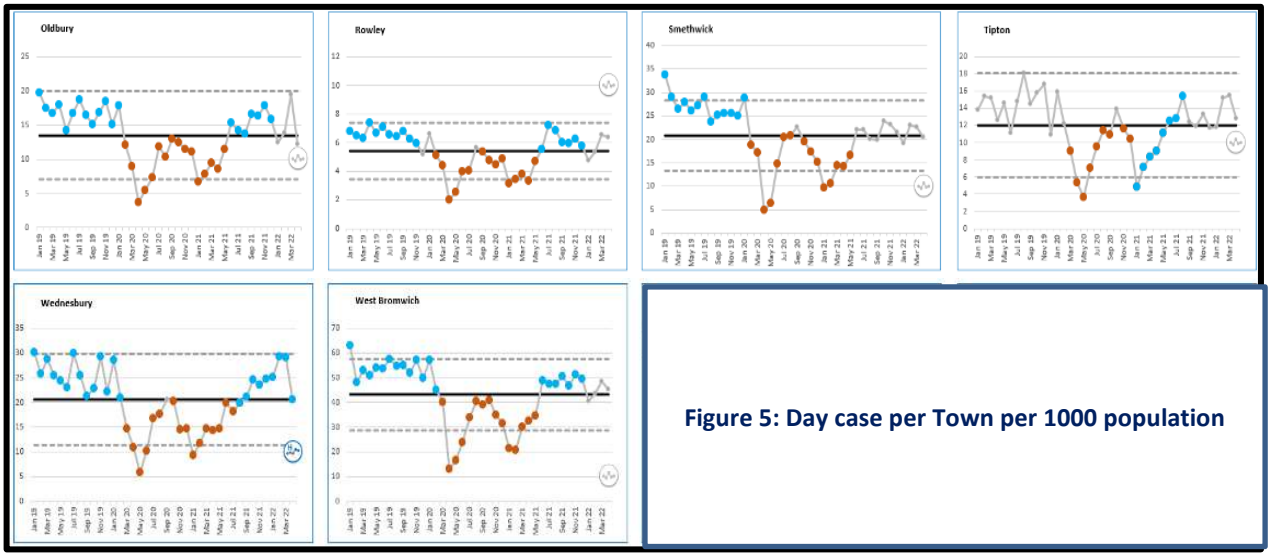

Figure 5: Day case per Town per 1000 population

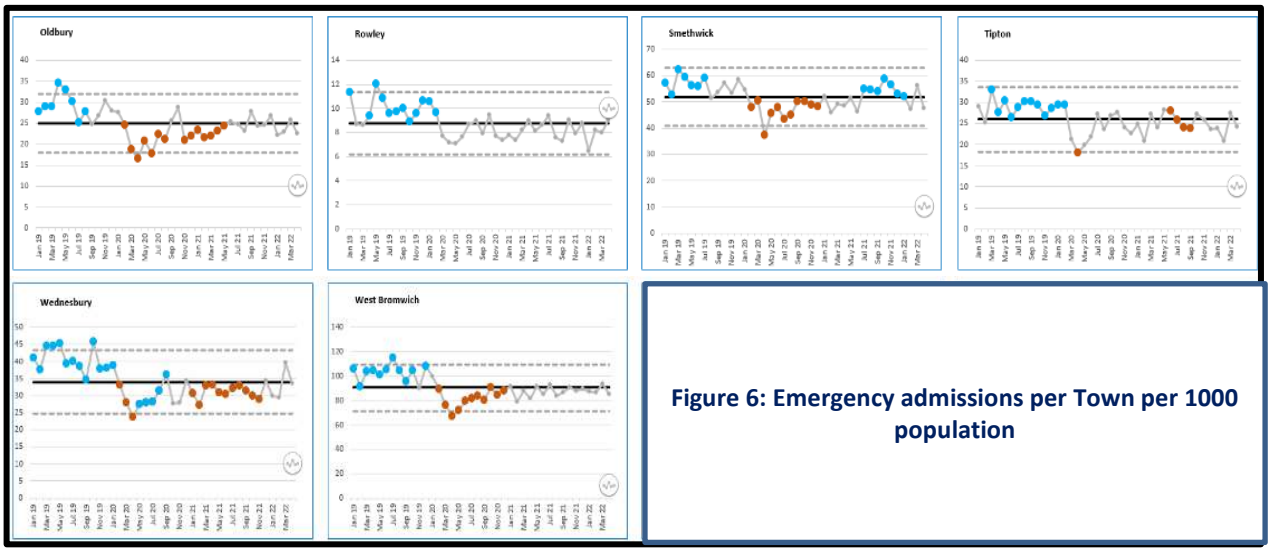

Figure 6: Emergency admissions per Town per 1000 population

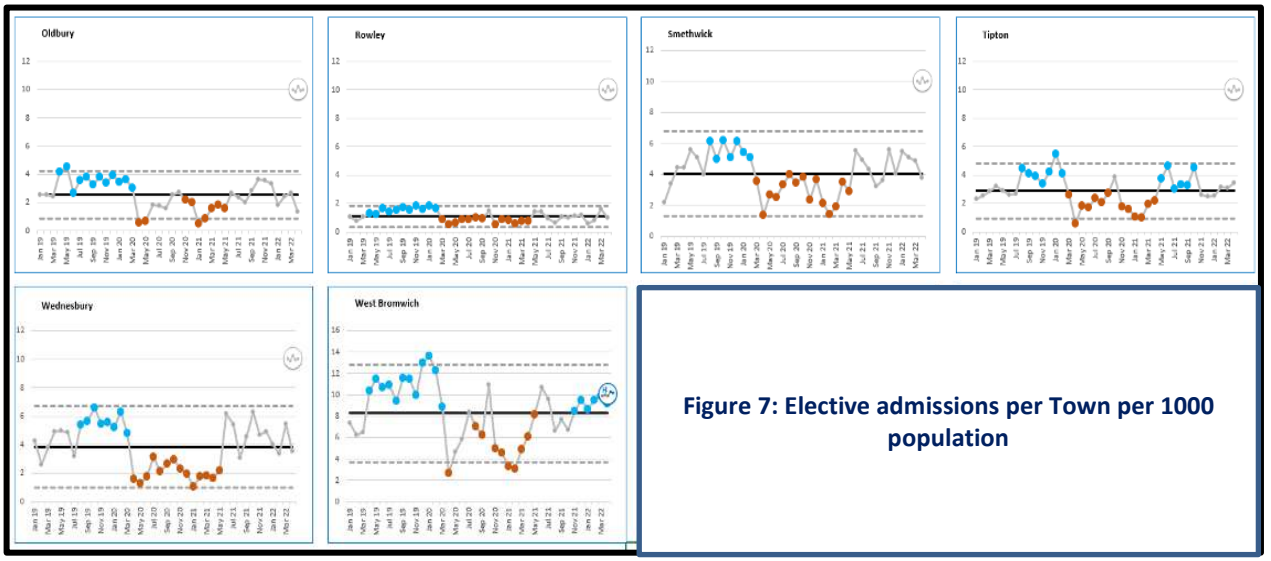

Figure 7: Elective admissions per Town per 1000 population

3.13 In order to achieve the outcomes associated with the data presented for each town and to ensure that community pathways are optimised to produce less urgent care demand, the development of **Care Navigation Centre (CNC)** is vital. The current plethora of community contact centres is now merged with a plan to transfer the acute medical Single Point of access into the CNC from June 1st. Phase 2 of the CNC design will aim to see all unscheduled care that is not traumatic injury or immediately life threatening to be redirected through CNC.

3.14 An engagement and stocktake session to plan the requirements and further work particularly around digital solutions and demand and capacity monitoring, supported by NHSE/I is planned for June.

3.15 The **virtual ward** offer is on target to exceed the required number of virtual beds for the population by September 2022 and the partnership have applied for system funding to enable recruitment into clinical roles to support delivery.

3.16 The case study in annex 1 features 6 separate occasions where a functioning CNC would have delivered a different outcome. For example, the use of clinically led triage rather than pathway led tools would enable flexibility in decision making. CNC will have a direct route to urgent community care through UCR2 and the hospital at home virtual ward which provides urgent investigations and intravenous medication at home. In addition access to the frailty virtual ward, direct access to specialist palliative care and dementia navigators are available to support people at home

4. Recommendations

4.1 The Trust Board is asked to:

- **a. NOTE** and gain assurance regarding the progress to date
- **b. DISCUSS** the impact the new delivery model will have on patient care and outcomes

Tammy Davies
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June 2022

Annex 1: Case study