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NHS
Sandwell and West Birmingham
NHS Trust

Report Title:	Place Based Partnership update		
Sponsoring Executive:	Daren Fradgley – Chief Integration Officer		
Report Author:	Daren Fradgley – Chief Integration Officer & Tammy Davies – Group Director - PCCT		
Meeting:	Trust Board (Public)	**Date**	6th April 2022

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

The paper provides an update on the development of the Sandwell Health and Care Partnership (SHCP) with brief analysis of the progress against the 7 key themes agreed for 21/22. A further more detailed update is given regarding the current position against the core themes for 22/23:

- The requirement to deliver an accountable place-based structure
- Delivery of the out of hospital planning requirements
- The building and delivery of an operational model

The plans to further develop in each of the 3 areas are discussed and a description is provided of the transformational work streams that make up the operational model, agreed at the Sandwell Place Based Partnership Board.

The paper also provides an update on the developments in Ladywood and Perry Barr. This section lacks the detailed analysis afforded to Sandwell Place due to the differing role of the Trust as key partner rather than host. However, Board members are asked to give due consideration to the emerging pathways within this area, the maturity and strength of relationships with GPs and the potential risks of inconsistent unclear discharge pathways between the 2 Places.

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	X	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?]*

Parts discussed in the March 2022 Integration Committee

4. Recommendation(s)

The Trust Board is asked to:

a.	**NOTE** progress made by the SHCP against the 7 key from 21/22 and Ladywood and Perry bar
b.	**DISCUSS** progress to date and plans to meet the 22/23 requirements

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

Trust Risk Register		
Board Assurance Framework	x	

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: 6th April 2022

Place Based Partnership update

1. Background

1.1 The end of the financial year has prompted a stocktake review of the Sandwell Health and Care Partnership to date. The evaluation has also considered the progress made against the criteria set out in the white paper, (*joining up care for people, places and populations, Department of Health and Social Care, 2022*) which was presented in detail to this Board last month, indicating early local maturity in Sandwell.

1.2 Progress for 21/22 in regards to the 7 agreed priorities which align to those set out in the white paper, have been presented in detail to the Sandwell Place Based Partnership Board and the Integration Committee. The self-assessed progress against the 7 agreed priorities is summarised in the Integration Committee (IC) highlight report and is available in admin control with the IC papers.

1.3 This report concentrates on detailing the 22/23 plan for the partnership showing early progress across several areas. The plan is based on 3 core themes

- The requirement to deliver an accountable place-based structure
- Delivery of the out of hospital planning requirements
- The building and delivery of an operational model

2. Sandwell Health & Care Partnership (SHCP): 22/23 plan

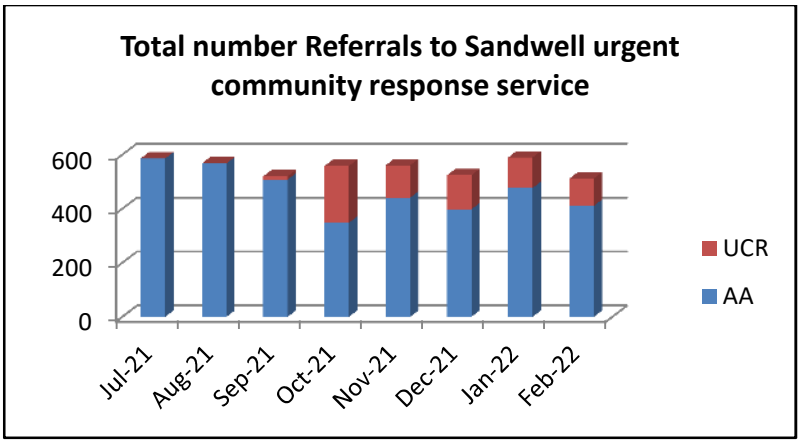
2.1 The next 12 months will focus on the delivery of the requirements set out in the white paper in **delivering an accountable Place based structure**. Whilst these themes provide a robust direction it is our intention to cross reference and provide assurance through the **CQC Well Led framework** to ensure consistency and safety. This will form the basis of the governance review and due diligence required by the system. The SHCP is committed to also working with the other Black Country Place Based Partnerships (PBP) and Ladywood and Perry Barr in an **action learning set mode** to ensure that we all learn together with development based on each other's experiences. We are also leading the thinking on coordination of an outcome framework that is aligned across the places with operational measure and transformational standards

2.2 **The out of hospital planning requirements** are designed to provide a robust model to minimise acute hospital demand through the provision of timely community intervention. The delivery against each area is largely coordinated by the Primary Care,

Community and Therapies (PCCT) clinical Group with variable levels of maturity. The out of hospital planning requirements include:

- **Urgent community response**
- **Virtual wards**
- **Discharge to assess**

2.3 From April 2022 there is an expectation that at least 75% of people meeting set criteria will have a **community response within 2 hours (UCR2)**. PCCT have provided a community admission avoidance service for several years offering same day rather than 2 hour response time. Since October 2021, urgent referrals have been re-prioritised to develop the 2 hour response service where indicated. The following table shows the total number of calls to the admission avoidance service and the proportion of calls meeting the UCR2 criteria.



2.4 The **Virtual Ward** model aims to provide intensive, consultant led management to people within their usual place of residence who would otherwise require acute hospital admission. Each Place has a mandate to prove 40-50 virtual ward beds per 100k population. Within Sandwell we currently have the following virtual wards in place / in design

Virtual ward	Detail	Stage of development	Number virtual beds
Acute Medicine (hospital at home)	For patients >16 years with an acute medical presentation. Supported by the acute medical team and community nursing and therapy teams, utilising point of care testing. This is a step up and step down service to expedite discharge and avoid admission and is a key element of the	Fully operational but with low levels of referrals and a requirement to work towards admitting to full capacity Average referrals per month - 30	40

	Midland Met care model		
Covid	For patients >18 years. Step up and step down service for people requiring additional monitoring including pulse oximetry. Delivered by the community respiratory team and supported by the respiratory physicians	Fully operational	50
Respiratory	For patients > 16 with exacerbation of COPD, asthma or bronchiectasis. Step up and step down service	In development – due to start in April 2022	30
Frailty	For patients > 65 with moderate to severe frailty who would otherwise require admission / prolonged hospital stay for medical, nursing or therapy support. A key element of the Midland Met care model	In development – due to commence in May 2022	50
Paediatric	Children requiring acute intervention, supported by the community paediatric service with consultant oversight	In development	30

2.5 There has been considerable progress in improving the discharge pathways from our acute beds into community services. Developed under the **Discharge to Assess (D2A)** model, we now have a functioning integrated discharge hub including community health and adult social care. The hub facilitates discharges from our acute sites regardless of patients' postcode with onward care provided for Sandwell residents (Birmingham Community Health Trust (BBCHC) and Birmingham social care provide onward care for Birmingham residents).

2.6 In order to fully implement the D2A model for Sandwell residents, it has been necessary to right size community service provision to enable appropriate **intermediate care** for people at home (**pathway 1**) and in extra assessment care home beds (**pathway 2**) . The previous model was funded for nursing and therapy provision for 20 virtual beds. Demand has dramatically increased and we are now providing an average of 135 pathway 1 beds and 50 pathway 2 beds. In order to mitigate risk and maintain capacity against current demand, rapid recruitment strategies are being deployed with approximately 35% of the total staff required for right sizing (WTE 71) recruited. The remaining recruitment will then be phased in year 2. Given the skill sets come from different professional back grounds the risk of recruitment delay can be mitigated.

2.7 The funding for the expanding community staffing establishment to meet the demand for pathway 1 and 2 has been obtained from the closure of 2 medically fit for discharge wards with reinvestment into both health and social care provision. This has been a key milestone in the maturity of the partnership with consensus across partners.

2.8 It is important to note that despite the early progress against out of hospital planning requirements, future success will rely on all partners contributing to future models. Over the coming months, priority will be afforded to deploying the **primary care DES** for Your Health Partnership (YHP) and extending this to a support offer for the whole of primary care. In addition a full market assessment of **adult social care provision** will be undertaken with a workforce delivery solution ahead of next winter.

2.9 **The building of a delivery model** will focus on 4 main areas:

- **Resilient communities** - – Equip communities with the resource, knowledge & support to maximise self-care, reducing reliance on existing health & social care services. This model will refocus efforts towards more preventative activity aimed at addressing inequalities and social determinants of health.
- **Town teams (integrated primary care)** - Citizens will receive health and care from a local, integrated team with the depth and breadth of skills to support the majority of needs for the local population
- **Intermediate care** - Integrated teams will provide specialist care across Sandwell to ensure residents receive urgent / timely interventions to reduce the need for hospital admissions / prolonged length of stay, reducing health inequalities
- **Care navigation** - There will be a single point of access that coordinates all professional and citizen health & care needs. This will maximise the use of community pathways, reducing unnecessary ED and GP attendances and improve access to care

2.10 The following table summarises the implementation progress against each transformation work stream and the metrics to be tracked

	Objectives	Progress to date	Operational metrics
Resilient communities	Each town to have an accessible multi-functional health & wellbeing hub and a support offer from social prescribers and 3rd sector (including housing, education, financial support)	Scoping of suitable estates underway Mapping of public health priorities Engagement with 3rd sector and community groups	Community pharmacy activity by attendance Social prescriber contacts Attendances at the Health & Wellbeing Hubs Increased utilisation of 3rd sector / community support groups
Town teams	Each town will have an integrated team inclusive of physical and mental health provision, social care and 3rd	Identification and agreement of 'in scope' teams. Transformation	Number of patients reviewed in complex & specialist MDTs Number of unplanned hospital

	sector. Teams will hold a dynamic data informed 'at risk' register to proactively support the citizens most at need Frequent MDTs will be provided Minimise duplication of referrals to multiple teams and multiple unnecessary contacts with a trusted assessor model	board formed Scoping IT solutions	and GP attendances for people on MDT caseloads Number of patients with personalised care plans Increase in staff retention & staff engagement scores Reduction in ambulance conveyances from care homes
Intermediate care	Completion of the right sizing community services exercise to ensure responsive therapy provision Consolidation of EAB beds in the Harvest view facility	Recruitment into expanding community services underway Harvest view facility due to open in July 2022	Number of patients assigned to each pathway Average Length of stay per pathway % of patients meeting the Urgent Community Response(UCR2) criteria – seen within 2 hours % of UCR2 patients admitted to ED % of patients discharged from an acute hospital bed within 24 hours of being deemed suitable
Care navigation	A single point of access for all citizens requiring health and care including UCR2, virtual wards, SDEC, AMU. Bed bureau for community beds. Integrated discharge hub Triage of WMAS data and 111 calls to increase community response and reduce ED / WMAS activity	Scoping of IT solution underway Virtual wards being formed Functional integrated discharge hub Dementia navigators (pathfinders)	Number of contacts to CNC by category and outcome disposition Number of patients per virtual ward (VW) & percentage hospital admissions per VW Average hospital Length of stay % of patient accessing services by ethnic origin, disability (accessibility)

3. Ladywood and Perry Barr

3.1 The Birmingham and Solihull (BSOL) approach is to treat Birmingham local authority area as a "Place" and a similar approach for the Solihull local authority area. This will mean that the subdivision of the wider Birmingham geography will be translated as localities of the Birmingham place. Ladywood and Perry bar will be one of these places; however, the delegation of decision making and budget is not confirmed.

3.2 In order to ensure the Trust retains a pivotal role in the area, executive presence on the Ladywood and Perry Barr Board has been maintained and there is a clear commitment from BSOL to continue engagement into all aspects of Midland Metropolitan University Hospital (MMUH) planning.

3.3 Local GPs are keen to retain independence in the area and forge stronger relationships with the Trust. This is intended to build on the work already commenced in areas such as the primary care echo service and more recently the work undertaken with the Trust diabetes team to support people with diabetes through a population health management approach. This has resulted in a reduction in patient related outcome measures (average Hba1C) and unplanned hospital attendances.

3.4 It is imperative that the identity of place is retained whilst ensuring a post code lottery effect is not seen in this community. For example, the virtual wards pathways are being shared with BSOL colleagues to ensure patients from this area discharged from our acute sites have equal access to consultant led virtual wards, albeit this will involve community service provision from BCHC. In addition the integrated discharge hub is operating a post code blind service supported by relationships and pathways with both BCHC and Birmingham adult social care

4. Recommendations

4.1 The Trust Board is asked to:

a) **NOTE** progress made by the SHCP against the 7 key from 21/22 and Ladywood and Perry bar
b) **DISCUSS** progress to date and plans to meet the 22/23 requirements

Tammy Davies
Group Director, PCCT

6th April 2022